Independent Investigation

into the

Care and Treatment Provided to Mr. Z

And Ms. X (deceased)

by the

Pennine Care NHS Foundation Trust

Commissioned by
NHS North West
Strategic Health Authority

Report Prepared by the Health and Social Care Advisory Service

Report Authored by Dr. Androulla Johnstone

Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Z was commissioned by NHS North West Strategic Health Authority pursuant to *HSG (94)27*[1]. This Investigation was asked to examine a set of circumstances associated with the death of Ms. X who was found killed on an acute psychiatric admission ward in Rochdale on the 13 August 2007.

Mr. Z received care and treatment for his mental health condition from the Pennine Care NHS Foundation Trust and was convicted of the manslaughter of Ms. X. It is the care and treatment that Mr. Z received from this organisation that is the main subject of this Investigation. Ms. X also received her care and treatment from the Pennine Care NHS Foundation Trust and the care and treatment that she received has also been reviewed in order to ascertain whether this contributed to her death in any way.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management who have granted access to facilities and individuals throughout this process. The Trust's Senior Management Teams have acted at all times in an exceptionally professional manner during the course of this Investigation and have engaged fully with the root cause analysis ethos of this Investigation.

1. Health Service Guidance (94) 27

2. Condolences to the Family and Friends of Ms. X

The Independent Investigation Team would like to extend their condolences to the family and friends of Ms. X. During the course of the inquest and trial, no relatives could be traced. This Investigation was also not able to either trace or make contact with any people who were friends or family members of Ms. X.

3. Incident Description and Consequences

Background for Mr. Z

Mr. Z who is of Ethiopian origin arrived in the United Kingdom and claimed asylum seeker status on 11 October 2005. Mr. Z was initially refused asylum seeker status on the 24 August 2006, however he was allowed to appeal and on the 15 January 2007 he was granted asylum and leave to stay in the United Kingdom until the 15 January 2012.[2] During this period Mr. Z claimed to have been a political prisoner who had been subject to detention and torture in his country of origin. Mr. Z is reported to have studied law at the University of Addis Ababa and to have worked as a Supreme Court Judge in Ethiopia. He is able to speak and to understand English well.

On his arrival in the United Kingdom Mr. Z was provided with various accommodations by the National Asylum Support Service. He was eventually settled in Leopold Court, which is a hostel in Rochdale. On the 1 August 2007, following a deterioration in his mental health, Mr. Z was admitted to Hollingworth Ward at the Birch Hill Hospital, Rochdale. At the time of his admission he was diagnosed as having a psychotic depression.[3] This was characterised by delusional thoughts, suicidal ideation and self neglect. He was thirty-six years old.

Background for Ms. X (deceased)

Ms. X was a fifty-nine year old lady at the time of her death. She was a small woman of slight build who experienced many ailments and poor physical health. Ms. X was originally from County Down in Northern Ireland and had settled in England several years earlier under unclear circumstances.

Ms. X had a long psychiatric history from before the time that she was sixteen years of age and had previously received a two and a half year prison sentence for assault. Ms. X had a history of alcoholism and a diagnosis that included personality disorder and psychosis with paranoid features. Ms. X was also reported as having a mild learning disability and was unable to read and write.

2 Ashworth Records P 6
3 Ashworth Records P9

At the time of her death Ms. X was an inpatient on Hollingworth Ward. She had been admitted for assessment on the 12 June 2007 because she was experiencing difficulties in living independently at her home.

Incident Description and Consequences

On admission to Hollingworth Ward Mr. Z was described as being tearful and as having some retardation of movement, which is a common feature with people who are depressed. During his time on the ward Mr. Z was described as being polite, however he felt a strong need to keep himself to himself as he thought the people around him may be plotting to kill him. Mr. Z retained his suicidal ideation throughout the thirteen days he was to spend on Hollingworth Ward and during this period he remained distressed and deluded.

Ms. X had been exhibiting volatile behaviour since her admission and had been aggressive and abusive to people on the street and with her neighbours. Her behaviour was unpredictable and it was felt that she would require more time on the ward in order to stabilise her mental health prior to her discharge. On no occasion prior to the 13 August 2007 had anyone observed Mr. Z or Ms. X to have previously spoken together or to have made any kind of contact with each other.

On the 13 August 2007, following a disturbed night when he was too afraid to sleep, Mr. Z stayed in his room throughout the day choosing to eat his meals there. Ms. X had spent most of the day off the ward and had not been observed as displaying any problematic behaviour. At approximately 17.20 hours a Care Assistant on Hollingworth Ward saw Mr. Z walking away from the female lounge carrying a belt in his hand. He looked at her and said *"I've done it"* he went on to say *"I had to kill her because she called me a spy".* The Care Assistant looked into the room and saw Ms. X laying on the floor and immediately hit the panic button. At this stage Ms. X was laid on her right side, her lips were blue and her complexion was pale. The Deputy Ward Manager (Ward Sister) arrived with another Care Assistant within a few seconds.[4] The alarm raised staff from a neighbouring ward. Two nursing staff remained with Mr. Z in his room, and the rest of the nursing staff undertook a resuscitation procedure on Ms. X.

4 Home office and Police Documentation File. P. 166

A faint pulse was found. Oxygen was administered but her pulse faded. An ambulance was called and resuscitation was commenced by the ward-based nursing team.

At 17.45 an emergency ambulance arrived, Ms. X was taken to the Accident and Emergency Department at Rochdale Infirmary at 18.06 where she would later be pronounced dead at 18.28.

The Police arrived onto the ward at 18.14 and Mr. Z was arrested on suspicion of murder at 18.16. Mr. Z was escorted off the ward by the Police who attended the incident and was taken into custody with immediate effect.[5]

On the 13 August Mr. Z was charged with the murder of Ms. X, he was admitted to Ashworth High Security Hospital on the 13 November 2007 for psychiatric assessment. On the 7 February 2008 Mr. Z pleaded guilty to manslaughter on the grounds of diminished responsibility when his plea was accepted. On the 17 April 2008 Mr. Z was sentenced at the Manchester Crown Court to indefinite detention. His place of disposal was Ashworth High Security Hospital.

5 Ashworth Records PP 16-17

4. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS North West (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 27,* issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved"*.

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS North West Strategic Health Authority. The Pennine Care NHS Foundation Trust did not wish to make any additions. The Terms of Reference were as follows:

1. To examine:

- The care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate);
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs;
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies;
- The adequacy of risk assessments to support care planning and use of the care programme approach in practice;
- The exercise of professional judgement and clinical decision making;
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical needs;
- The extent of services' engagement with carers; use of carer's assessments and the impact of this upon the incident in question;
- The quality of the internal investigation and review conducted by the Trust.

2. To identify:

- Learning points for improving systems and services;
- Development in services since the user's engagement with mental health services and any action taken by services since the incident occurred.

3. To make:

- Realistic recommendations for action to address the learning points to improve systems and services.

4. To report:

- Findings and recommendations to the NHS North West Strategic Health Authority Board as required by the SHA.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of Pennine-based Mental Health Services. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair, Nurse Member and Report Author

Investigation Team Members

Dr. Rizkar Amin	Consultant Psychiatrist Member of the Team
Dr. Len Rowland	Research and Development Director, Health and Social Care Advisory Service, Clinical Psychologist Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service
Mrs. Louise Chenery	Stenography services

Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Investigation Methodology

On the 7 April 2010 NHS North West (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in Section Six of this report. The Investigation Methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. Z and Ms. X and all witnesses to this Investigation.

Consent and Communications with Mr. Z

During the course of this Investigation Mr. Z has been detained at Ashworth High Security Hospital. On the 2 June 2010 a letter was sent to him by NHS North West requesting his consent for the Independent Investigation Team to access his clinical records and a consent form was enclosed. Mr. Z did not respond. On the 15 July a second letter requesting consent and another consent form was sent to Mr. Z. Both of these letters set out the purpose of the Investigation and offered the opportunity of a face-to-face meeting so that any questions Mr. Z had could be addressed directly.

Mr. Z did not respond to the written requests for his consent. It was decided that a Senior Officer from the Strategic Health Authority and the Investigation Team Chair would visit Mr. Z in order to explain the Investigation process to him. After full consultation with the Responsible Medical Officer regarding the capacity of Mr. Z a meeting took place on the 28 July 2010. At this meeting the purpose of the Investigation was explained to Mr. Z and he signed the consent form. On this occasion the Investigation Team Chair explained that members of the Investigation Team would come and talk to Mr. Z if he wished to become involved and contribute to the process. At the time of writing this report Mr. Z had not taken up the offer to work with the Investigation Team.

At the time of completing this report a Senior Officer from the Strategic Health Authority and the Investigation Team Chair were preparing to meet with Mr. Z to share the findings of the report with him.

Communications with the Victim's Family

Unfortunately no friends or family members of the deceased could be traced despite a full Police inquiry and televised appeal at the time of the incident.

Communications with the Family of Mr. Z

It was not possible to make contact with the family of Mr. Z either in Ethiopia or Canada. Mr. Z currently has no friends or family living in the United Kingdom.

Communications with the Pennine Care NHS Foundation Trust

In June 2010 NHS North West wrote to the Pennine Care NHS Foundation Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices of HSG (94) 27 had been commissioned to examine the care and treatment of Mr. Z. Following this correspondence the Independent Investigation Team Chair made direct contact with the Trust via telephone on the 29 June.

On the 4 August 2010 the Chair of the Independent Investigation Team met with the Pennine Care NHS Foundation Trust Top Team which included the Chief Executive, the Director of Nursing, the Medical Director and the Deputy Director of Nursing and Integrated Governance, who was identified as being the Trust Liaison Person for the Investigation. On this occasion the Investigation process was discussed and an invitation was made for a workshop to take place to provide a briefing opportunity for all those who would be involved with the Investigation.

On the 11 August 2010 the Trust received a letter from the Strategic Health Authority formally requesting that Mr. Z's clinical records be released to the Independent Investigation Team.

A workshop was held on the 1 September 2010 for all those witnesses who had been identified as needing to be called for interviews by the Investigation Team. The workshop provided an opportunity for witnesses to have the process explained to them in full. Advice was given regarding the writing of witness statements and the interview process was discussed in detail.

Mr. Z Investigation Report

Between the first meeting stage (August) and the formal witness interviews (November) the Independent Investigation Team Chair worked with the Trust Liaison Person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

On the 8 December 2010 a meeting was held between the Independent Investigation Team Chair and the Trust Top Team. The purpose of this meeting was to inform the Trust of the headline findings of the Investigation and to commence the factual accuracy stage of the process. On this occasion the Trust was invited to comment upon the recommendation section in the report and to contribute further after a period of reflection.

The draft report was sent to the Trust for factual accuracy checking on the 22 February 2011. Relevant clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Communication with North West Ambulance NHS Trust

On the 14 October 2010 the Investigation Team Chair made contact with the North West Ambulance NHS Trust via telephone. The Assistant Director of Healthcare was identified as being the named liaison person for the Investigation process. A letter was subsequently written on the 18 October 2010 detailing the work of the Investigation and the required levels of input from the Ambulance Trust.

On the 4 November 2010 the Ambulance Service Assistant Director of Healthcare met with the Investigation Team Chair. On this occasion the case was discussed with particular reference to the Ambulance Service and its involvement in the attempted resuscitation of Ms.

X. The Ambulance Service subsequently sent documentary evidence to the Investigation Team in the form of a call log which detailed the events of the 13 August 2007.

Communication with NHS Heywood, Middleton and Rochdale Primary Care Trust (PCT)

The Independent Investigation Team Chair made contact with NHS Heywood, Middleton and Rochdale (the PCT) and a liaison person was identified. The PCT provided GP clinical records and performance management data to the Investigation Team.

On the 3 November 2010 a meeting was held between the Independent Investigation Team Chair and the Primary Care Trust Medical Director. The purpose of this meeting was to discuss the Investigation process and to explore how best the Primary Care Trust would like to engage with the process.

On the 24 February 2011 another meeting was held with the Primary Care Trust. The purpose of this meeting was to share the headline findings of the Investigation and to provide an opportunity for a contribution to the report recommendations to be made.

The draft report was sent to the PCT in April 2011 for factual accuracy checking and recommendation development.

Completion of the Process

It was agreed that a formal workshop would be held with the Pennine Care NHS Foundation Trust and key stakeholders directly prior to the publication of this report.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon compliant processes.

During the thirteen-day period that Mr. Z received his care and treatment from Pennine Care NHS Foundation Trust he was seen by many people. The Independent Investigation Team took the decision to interview each of the Medical Officers involved in his care, the Named Nurse and a sample of staff that provided the principle aspects of Mr. Z's care and treatment over this period and who were responsible for the formulation of his case management. The

Responsible Medical Officer and key nursing staff involved in the care and treatment of Ms. X were also called as witnesses. The Investigation Team visited the acute inpatient psychiatric ward on two occasions and met the staff who were working there. The total number of witnesses interviewed formally by the Independent Investigation Team was 20; the number of people met informally was six. The witnesses who attended for interview are set out below in table one.

Table One

Witnesses Interviewed by the Independent Investigation Team

(3-5 November 2010)

Date	**Witnesses**	**Interviewers**
3 November 2010	Trust CEO Trust Director of Nursing *** Responsible Medical Officer for Ms. X ***	Investigation Team Chair (Nurse) Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer
4 November 2010	Consultant Psychiatrist 1 Specialist Trainee *** Named Nurse *** Inpatient Service Manager *** Deputy Ward Manager Nurse 1 ***	Investigation Team Chair (Nurse) Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer
5 November 2010	Healthcare Assistant 1 Healthcare Assistant 2 Healthcare Assistant 3 *** Trust Non Executive Director leading the Internal Investigation Independent Internal Investigation Author *** Nurse 2 Nurse 3 *** Trust Medical Director *** Service Director Community Service Manager ***	Investigation Team Chair (Nurse) Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer

	Specialist Registrar ***	

Salmon Compliant Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview;

2. witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It

was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

12 October 2010. On this occasion the Team examined the timeline based on what could be ascertained from analysing the documentary evidence. The witness list was confirmed and emerging issues were identified prior to the interviews.

21 October 2010. A second meeting took place to discuss further issues raised from the secondary literature.

3-5 November 2010. Between these dates witness interviews took place. During this period the Investigation Team took regular opportunities to re-examine the timeline, re-evaluate emerging issues and to discuss additional evidence as it arose. On the 5 November, using the Terms of Reference and the timeline as guidance, the Team developed subject headings that required further examination.

Between the 5 November and the 15 November 2010 each Team Member prepared an analytical synopsis of identified subject headings in order to conduct an-in-depth Root Cause Analysis process.

15 November 2010. On this day the Team met to work through each previously identified subject heading utilising the 'Fishbone' process advocated by the National Patient Safety Agency (NPSA). This process was facilitated greatly by each Team Member having already reflected upon the evidence prior to the 15 November and being able to present written, referenced briefings at the meeting. The 'Five Whys' process was also used.

Following this meeting the report was drafted. The Independent Investigation Team Members contributed individually to the report and all Team Members read and made revisions to the final draft.

Other Meetings and Communications

The Independent Investigation Team Chair met on a regular basis with NHS North West throughout the process. Communications were maintained in-between meetings by email, letter and telephone.

Communications also took place with Ashworth High Security Hospital in the pursuit of clinical records and access to Mr. Z.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.

3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

During the course of this investigation 793 pages of clinical records have been read and some 4,000 pages of other documentary evidence were gathered and considered. The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Mr. Z's Pennine Care NHS Foundation Trust records
2. Mr. Z's Ashworth Hospital forensic records
3. Mr. Z's Home Office records
4. Mr. Z's Rochdale-based GP records
5. The transcription of the Crown Court proceedings
6. The Pennine Care NHS Foundation Trust Internal Investigation Report and action plan
7. Health and Safety Executive archive
8. The Pennine Care NHS Foundation Trust Internal Investigation Archive
9. Pennine Care NHS Foundation Trust action plans
10. Secondary literature review of media documentation reporting the death of Ms. X
11. Independent Investigation Witness Transcriptions.
12. Pennine Care NHS Foundation Trust Clinical Risk Clinical Policies, past and present
13. Pennine Care NHS Foundation Trust Incident Reporting Policies
14. Pennine Care NHS Foundation Trust Clinical Supervision Policy
15. Pennine Care NHS Foundation Trust Being Open Policy
16. Pennine Care NHS Foundation Trust Operational Policies
17. Healthcare Commission/Care Quality Commission Reports for Pennine Care NHS Foundation Trust services
18. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006
19. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

20. The Impact and Integration of Asylum Seekers on the Community. Report of the Select Committee 2 (Rochdale 2001)

21. Research Report 36. *Helping new refugees integrate into the UK: baseline data analysis from the Survey of New Refugees*, Home Office (2009)

22. Department of Health, *Celebrating our Cultures: Mental Health Promotion with Refugees and Asylum Seekers* (2004)

23. Asylum Support Policy Bulletin 31. Dispersal Guidelines (2009)

24. New Zealand guidance on refugees and torture.

25. Home Office, *Asylum Seekers in Dispersal: Healthcare Issues,* (2003)

26. Home Office, *Research Report 12: The Gateway Protection Programme: an evaluation: An overview of Immigration Research and Statistics (IRS) research exploring the integration of refugees resettled under the UK's Gateway Protection Programme in Sheffield, Bolton, Hull and Rochdale.* (2009)

9. Profile of the Pennine Foundation NHS Trust Services (Past, Present and Transition)

Profile of Pennine Care NHS Foundation Trust

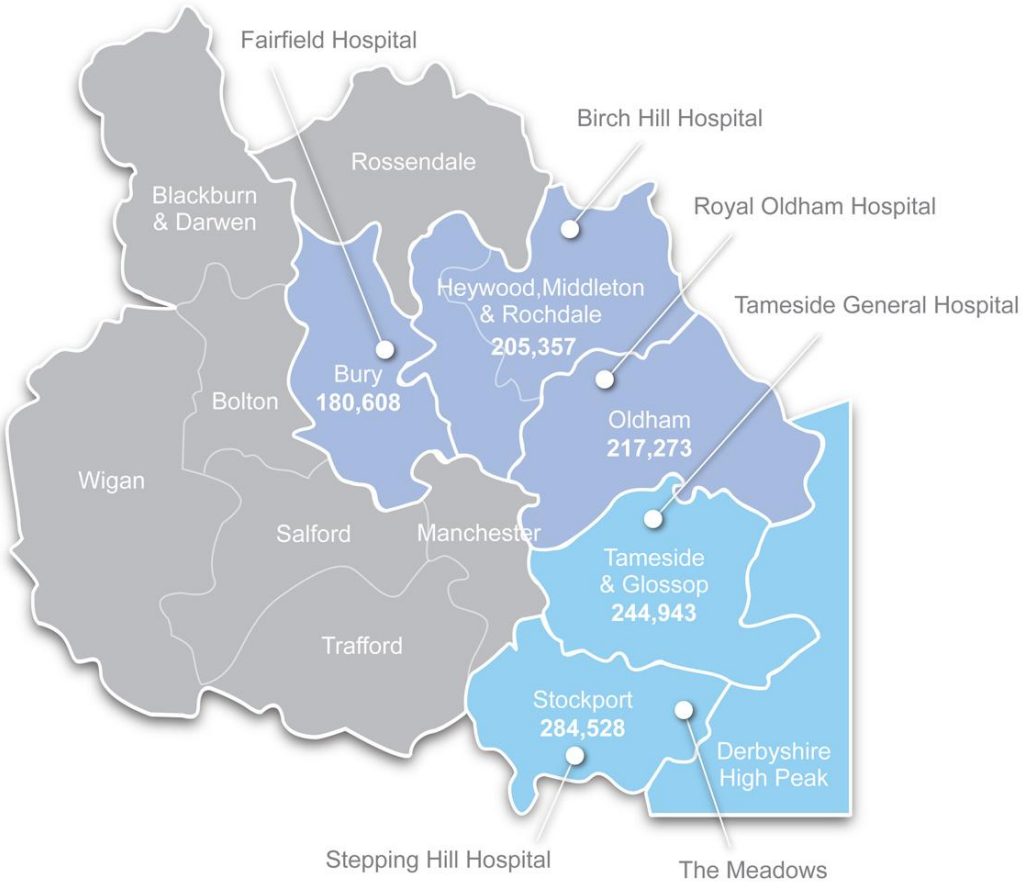
Pennine Care NHS Foundation Trust was established in July 2008 as the 100th NHS Foundation Trust. The Trust provides mental health and specialist drug and alcohol services to a population of almost 1.2 million people throughout the boroughs of Bury, Rochdale and Oldham, Stockport, and Tameside and Glossop. The Trust is also commissioned to provide mental health services to parts of the High Peak, East Lancashire and North Manchester areas. Prior to becoming a Foundation Trust the organisation was known as Pennine Care NHS Trust and was formed in April 2002.

Table Two

Overview of the Trust at a Glance

Trust turnover:	Total £219m Bury Community Services £27m Oldham Community Services £30m HMR Community Services £34m Existing Mental Health £128m
Bed numbers	542 mental health beds 19 community beds
Boroughs	Bury, Oldham, Rochdale, Tameside and Glossop, Stockport
Chief Executive	John Archer
Chairman	John Schofield

In April 2010, in addition to the provision of mental health services, the Trust was selected as the preferred option for the provision of community services for Bury, Oldham and Heywood, Middleton and Rochdale (previously part of the respective Primary Care Trusts). The Trust commenced the management of these services from April 2011. These services consist of a wide range of health and allied healthcare professionals and disciplines that support General Practitioners in the delivery of physical health care treatments and support, including Health Visitors, School Nurses, District Nurses, Dental services and Audiology.



In the above map, the areas in darker blue represent those boroughs where Pennine Care NHS Foundation Trust will provide both mental health and community services. The areas in light blue represent those boroughs where Pennine Care NHS Foundation Trust provides mental health services. Grey areas show the boroughs next to the Trust's footprint.

Since 2002, the Trust has developed a range of ways to engage with service users and carers. The organisation embarked on a significant expansion in community involvement when it became a Foundation Trust, recruiting over 11,000 members and electing a 'Council of Members' from the wider membership. All three community service providers bring a culture of user and carer engagement which provide firm foundations on which to build on this work and increase Foundation Trust membership.

The Trust continues to value the support that it has from users and carers and looks forward to building on this through development of its membership and Council of Members in the new, expanded organisation.

In 2009, Pennine Care was rated 'Excellent' in its Annual Health check by the Care Quality Commission – the health watchdog for England - for both its Quality of Services and its Use of Resources. This rating places the Trust amongst the highest performers in the country. The Annual Health Check assesses NHS Trusts on all aspects of the care that they deliver, including the quality of the services they provide to patients and the public, and how well they manage their finances and other resources such as their property and staff.

The Trust works in partnership with Local Authorities, Primary Care Trusts, Health Authorities and the independent sector. The Trust is committed to providing fully integrated, continually improving and locally accessible mental health services in a range of hospital and community settings. User and carer involvement is a priority for the Trust, to facilitate the development of services that are appropriate, accessible and responsive.

The Trust vision is to *"'improve the patient experience' when patients come into contact with our services. Everyone working for the Trust, no matter what their role, has a part to play in improving the patient experience."*

The Trust strategy is to *"provide high quality health and social care that improves an individual's opportunity for social inclusion and recovery. In partnership with the wider community, our care will improve mental wellbeing and drive out health inequalities."*

The Trust Mission statement says the following:
"Our Trust, working in partnership with Local Authorities, Primary Care Trusts, Health Authorities and the independent sector, is committed to providing a fully integrated, continually improving and locally accessible specialist mental health service, in a range of hospital and community settings. We aim to involve users and carers, support staff and to maintain a high quality environment."

Mental Health Service Provision

Trust mental health services are provided by staff from a range of clinical and non-clinical backgrounds (medical, nursing, technical, administration and management, social work etc.). The Trust provides a range of core services for people who have serious mental illness (e.g. schizophrenia, bipolar disorder) and common mental health problems (e.g. depression, anxiety) and dementia. These services are covered by a block contract.

The services provided are:

- Primary Care Mental Health Services including Increasing Access to Psychological Therapies (IAPT);
- Working Age Adult Inpatient and Community Services, including Crisis Resolution and Home Treatment, Assertive Outreach and Early Intervention;
- Older People's Inpatient and Community Services;
- Community based Drug and Alcohol Services;
- Child and Adolescent Mental Health Services (CAMHS);
- Psychiatric Intensive Care (PICU);
- Low Secure Rehabilitation and Step Down Rehabilitation services which are gender and age specific, designed to safely integrate individuals back into their local communities.

The Trust is also working with specialist commissioners to develop new services to aid recovery and present a broader range of options for local people in need of mental health services within the NHS. The Trust provides mental health services as follows:

Table Three

Trust Mental Health Service Provision

Borough	**Site**	**Adult beds**	**Older people's beds**	**Rehab beds**	**CAMHS Beds**	**Total**
Bury	Fairfield General Hospital (DGH)	44	16	0	22	82
Oldham	Royal Oldham Hospital (DGH)	44	22	0	0	66
Oldham	Rhodes Place	0	0	8	0	8
Rochdale	Birch Hill Hospital	40	25	0	0	65
Rochdale	Stansfield Place	0	0	12	0	12
Stockport	Stepping Hill Hospital (DGH)	46	22	25	0	93
Stockport	The Meadows	0	45	0	0	45
Stockport	Heathfield House	0	0	19	0	19
Tameside and Glossop	Tameside General Hospital (DGH)	45	38	69		152
Total		**219**	**168**	**133**	**22**	**542**

Hollingworth Ward

Mr. Z and Ms. X were inpatients on Hollingworth Ward at the time of the incident. Hollingworth Ward is part of Birch Hill Hospital in Rochdale. Birch Hill Hospital was originally built to provide day care services. Consequently the ward was not purpose built for modern acute mental health care. The ward was, and is currently, a sixteen bedded unit for the inpatient assessment of adults of working age with acute mental health problems and caters for both men and women. At the time Mr. Z and Ms. X were receiving their care and treatment the average length of stay was 24 days.

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Z and on his care and treatment from mental health services.

Background Information

Mr. Z originates from Ethiopia and was born there in 1971. The accounts given regarding Mr. Z's background by Mr. Z himself and by his family differ greatly (this in itself should not be seen as unusual as families of asylum seekers often deny knowledge of any imprisonment or torture as they seek to avoid political censure within the hostile regime that they are often still living in). The Independent Investigation Team has taken the following accounts from psychiatric reports prepared by Ashworth High Security Hospital and from Home Office records. There have been three different accounts given regarding Mr. Z's background. They are set out below.

Account Number One (from Mr. Z). This account was given to the clinicians at the Ashworth High Security Hospital on the occasion of Mr. Z's pre-admission report *circa. Summer 2007*.

Mr. Z had an uneventful and successful childhood in that he eventually studied for a law degree at Addis Ababa which he obtained in 1992. Between 1995 and 1998, despite his young age, shortly after completing his degree he was appointed as a Supreme Court Judge, this was due to regime change which had destabilised the judiciary.

Mr. Z worked in this capacity for a period of three years. Mr. Z said that he was placed under pressure to sentence members of the Government's opposition party. Because he allowed these individuals to be released due to a lack of evidence he himself was arrested and imprisoned and he was subsequently detained as a political prisoner for a period of six years. During this period Mr. Z stated he had been tortured.

In the sixth year of his detention a fire broke out in the prison which facilitated his escape. He made his way to the house of a friend and was then taken to the Sudanese border with a forged passport. From the Sudan Mr. Z made his way to the United Kingdom in 2005.[6]

Account Number Two (from Mr. Z)

On the 8 February 2008 Mr. Z gave a different account of his history. Mr. Z confirmed that he gained his law degree between 1993 and 1998 and had been appointed as a Supreme Court Judge following the completion of his studies. Mr. Z stated that he had been imprisoned for a period of 12 months after he had refused to keep five Government opposition members in custody as there was no evidence to support the allegations against them. Mr. Z said that he had not been tortured, however he had been subjected to intense military-style training, a beating and reduced food rations.

Mr. Z was released from prison and he then went to work as a Department Manager for the Post Office. Mr. Z was of the view that he experienced "*political interference*" during this period that prevented him from doing his job. He was unclear what form this political interference took. However Mr. Z obtained a forged passport and used this to travel to the Sudan where he flew to the United Kingdom in 2005. On arrival in the United Kingdom Mr. Z carried out the instructions from friends to embellish his story for the purpose of claiming asylum.

Mr. Z lost his first application for asylum as the Judge had not believed his story. However he was able to appeal and asylum was granted.[7]

Account Number Three (from the family of Mr. Z)

Mr. Z's mother was contacted via telephone by Ashworth Hospital Social Workers. Mr. Z's mother confirmed that her son left Ethiopia in 2005 and that he had been a law student before gaining some employment in the Courts in a legal capacity. She confirmed that Mr. Z had worked as a manager of a post office prior to leaving the country. She stated that Mr. Z had not been in prison. Mr. Z had never shown signs of mental illness whilst living in Ethiopia.[8]

6 Ashworth Records P 4
7 Ashworth Records P 5
8 Ashworth Records PP 8-9

Independent Third Party Information

Request for Asylum

Mr. Z claimed asylum on the 11 October 2005, this was subsequently refused on the 24 August 2006. Mr. Z then lodged an appeal on the 19 September 2006 and on the 7 November 2006 his appeal was allowed. On the 15 January 2007 Mr. Z was granted asylum and leave to stay in the United Kingdom until 15 January 2012.

Mr. Z did not require an interpreter at the initial interview with the Border and Immigration Agency (part of the United Kingdom Immigration Service) on the 15 October 2005. He gave his last permanent address as being "*Gambella Region prison cell".* When interviewed for asylum he claimed to have had a "*mental condition"* and that he was not *"stable".*[9] Mr. Z gave information at this stage in accordance with 'account number one' (see above).

By the 31 October 2005 Mr. Z was resident at Milbank Induction Centre, Ashford, Kent. Mr. Z was interviewed by the Border and Immigration Agency on the 8 March 2006. The account that Mr. Z gave regarding his circumstances remained broadly in line with the information that he had given previously. He was questioned at length in order to verify the truth of this account. There are no recorded details available to understand why Mr. Z's application for asylum was initially rejected and this decision overturned at appeal.[10]

On the occasion of Mr. Z's appeal he was able to present the following information:

- a certificate of his Bachelor of Law degree with an accompanying grade report (1992);
- an ID card of the Gambella Regional Supreme Court stating that Mr. Z was a Supreme Court Judge;
- a letter of appointment from the Gambella Regional State Council;
- a letter of appointment from the Gambella Regional State Supreme Court;
- a letter of representation from the Gambella Regional State;
- photograph of Gambella Regional State Supreme Court Judges taken during one of its hearing sessions (the presiding Judge was Mr. Z);

9 Ashworth Records P 6
10 Ashworth Records P 8

- corroborating evidence from the TOMAR newspaper (stating that Mr. Z had been detained in jail on the 20 May 1998 following an unpopular legal ruling that offended the Government);
- corroborating evidence from the SEIFE NEBELEBAL newspaper (stating that Mr. Z had been detained in jail on the 20 May 1998 following an unpopular legal ruling that offended the Government. Mr. Z's imprisonment attracted a degree of national concern and he was supported by a popular public demonstration of support);
- a letter of dismissal from the Gambella Regional State Council;
- decision of the Regional Supreme Court (one of two files that led to the detention in prison of Mr. Z);
- a letter of recommendation from the Amhara Regional State Supreme Court;
- a letter releasing Mr. Z from his role at the Supreme Court with no reason given;
- a letter from Mr. Z's girlfriend confirming 'account number one' that Mr. Z gave originally.[11]

Comment from the Independent Investigation Team
At the time of writing this report it would appear that no single agency has in its possession a full set of information regarding Mr. Z. Conflicting information, especially from family members remaining in the country of origin who are fearful of their continued wellbeing, is a common feature with individuals who are seeking asylum in this country. The doubts raised in the minds of the clinicians assessing Mr. Z following the death of Ms. X regarding the veracity of his asylum seeker credentials would perhaps have been allayed had they been in receipt of his full Home Office records.

Accommodation in the United Kingdom

Mr. Z was not able initially to find work in the United Kingdom due to his asylum seeker status. After his right to stay in the United Kingdom was confirmed he remained unable to find employment. Mr. Z lived in various accommodations provided by the National Asylum Support Service and was eventually sent to live in Blackburn for six months. At the time of his admission to Birch Hill Hospital under the care of the Pennine Care NHS Foundation

11 Home Office and Police Documentation File

Trust on the 1 August 2007 Mr. Z was resident at a hostel called Leopold Court in Rochdale. He had commenced his residency there on the 5 June 2007.[12]

Mr. Z told clinicians at Ashworth Hospital that he liked Leopold Court but that the people there were *"not good".* Mr. Z felt that from the moment he arrived the residents and the staff were hostile towards him, and it appears that from this time his psychotic symptoms first became evident.[13]

Clinical History with the Pennine Care NHS Foundation Trust

It was evident from the examination of the GP records that Mr. Z had been diagnosed as having problems with depression as early as November 2005 once resident in the United Kingdom. It was not certain to what extent he ever received treatment for this condition, however on the 14 May 2007 whilst resident in Blackburn, and prior to his move to Rochdale, his GP prescribed him with 28 Trazodone Capsules 50mg (an anti depressant).[14]

It was estimated that within three or four days of Mr. Z arriving at Leopold Court on the 5 June 2007 he began to exhibit an abnormal mental state.[15] At this time Mr. Z felt that people were hostile towards him, were taking photographs of him and he also heard voices telling him he was a British spy and that he was working for the British Government. Mr. Z began to believe that people were trying to kill him and that his food was being poisoned.

12 June 2007. Mr. Z registered with a General Practice in Rochdale. It was recorded that Mr. Z had been a political prisoner for seven years and that he had been subject to torture. It was also recorded that Mr. Z experienced flashbacks and nightmares and that he had scars on his feet from being beaten. Mr. Z said he was depressed and tended to keep away from people. The GP recorded a plan to refer Mr. Z to psychology services for counselling.[16] At this stage Mr. Z was running out of his Trazodone capsules and hostel staff had suggested that he ask his GP for more. Mr. Z did not do this, and the GP did not appear to note that Mr. Z had been prescribed this medication in May by his previous GP surgery.

12 Ashworth Records P 9
13 Ashworth Records P 9
14 GP Record PP 12 and 20
15 Ashworth Records P 10
16 GP Records PP 5-6

1 August 2007. Mr. Z was taken to the Accident and Emergency Department at Rochdale Infirmary by ambulance. He arrived at 12.11 hours and was triaged at 12.12 hours. Staff at the hostel in which he was living had grown increasingly concerned about him and had referred him to the hospital. They did not accompany him. The Triage Nurse noted that Mr. Z had been reported as crying in his bed at the hostel all day and that he presented with *"marked distress".*[17]

At 12.45 hours Mr. Z was seen by a Senior House Officer (SHO) in the Accident and Emergency department. Mr. Z said that he was afraid people would harm him and that he had kept his windows and doors locked for several days to keep them out. He also said that he had been feeling depressed for two months. On this occasion it was noted that Mr. Z had poor eye contact and that his speech was slow. No evidence of hallucinations could be observed. Mr. Z was referred to the Access and Liaison Service (a mental health team).[18]

At 13.50 hours the Nurse from the Access and Liaison Service met Mr. Z and sought information about him from Leopold Court. She was told that he had been staying in his room and cowering under his sheets. His fellow residents were becoming concerned about his *"bizarre hallucinations"* and had reported him to the hostel staff. The catalyst for his referral to medical services was an event that had occurred the night before when he came out of his room completely naked and could not understand why this was wrong. Hostel staff had tried to contact the GP but could only access an answer machine.[19] The Nurse found Mr. Z difficult to assess and decided to refer him to the On Call Psychiatrist.

At 15.25 hours Mr. Z was seen by the On Call Psychiatrist. Mr. Z told the doctor that he did not see a way out of his troubles and that he would have to *"kill myself or kill them".* It was also noted that Mr. Z was not eating properly, could not sleep and that his energy was low. *"? GP gave Tradozone"* was recorded. During this consultation the doctor assessed Mr. Z as having motor retardation, as holding delusional beliefs about his fellow residents at the hostel and as having thoughts about hanging himself. The initial diagnosis was *"psychotic depression"* and it was ascertained that Mr. Z was willing to be admitted into hospital on an informal basis and a bed was made available to him on Hollingworth Ward at the Birch Hill

17 Medical Records. P.5
18 Medical Records. P. 6
19 Medical Records. P. 7

Hospital. The doctor took the decision to admit Mr. Z with a plan to observe him without medication for a 24 hour period.[20]

At 20.00 hours Mr. Z was admitted as an informal patient onto Hollingworth Ward Birch Hill Hospital in Rochdale. The admission was carried out by his allocated Named Nurse. It would appear that Mr. Z's Accident and Emergency clinical records did not accompany him, however the assessing doctor came onto the ward and discussed Mr. Z with the nursing staff. The Named Nurse filled in the Admission and Assessment Details Form and noted that Mr. Z had been experiencing problems for two months previously and that he had been *"isolative and increasingly paranoid, feels people are talking about him, feels people are trying to poison him".*[21] This form also documented *"?psychotic depression / PTSD".*[22] This initial assessment recorded that Mr. Z had been a political prisoner and had been subject to torture and had been granted asylum in this country. Mr. Z was noted to be tearful with some retardation of gestures, he was polite and calm. Mr. Z's suicidal ideation was recorded and the Named Nurse decided that 15 minute observations were required.[23] A Salford Tool for Assessment of Risk (STAR) initial risk assessment was completed. This assessment identified that Mr. Z had thoughts of suicide, but did not identify any potential risks of violence to others. The Named Nurse indicated on the form that a full risk assessment would be required.[24] Mr. Z was not seen by a ward doctor.

2 August 2007. At 08.00-09.30 hours the Named Nurse finalised the risk assessment process and completed a care plan for Mr. Z based upon this risk assessment. The care plan noted that Mr. Z had been *"recently low in mood with fleeting suicidal thoughts".* [25] The plan was to develop a therapeutic relationship with Mr. Z, to allow 1:1 time with Mr. Z so that he could ventilate his feelings, to ensure Mr. Z was nursed on the appropriate level of observations, and to commence medication, assess his risk of suicide and to discuss with the multidisciplinary team. Mr. Z was to be encouraged to participate in ward activities. Mr. Z reported that his sleeping pattern was poor and that he experienced nightmares, these needs were identified in a separate care plan.

20 Medical Records PP 8-11
21 Nursing Records P 13
22 Nursing Records P 14
23 Nursing Records PP 14-16
24 Nursing Records PP18-21
25 Nursing Records P30

A ward round was also held on this day. Mr. Z was seen by the Consultant Psychiatrist, the Named Nurse and the Senior House Officer were also present. It was recorded that Mr. Z had suicidal thoughts but that he appeared more settled since arriving on the ward. It was also recorded that there were no indications that he presented any risk of harm to others. The plan was to assess him for 48 hours medication free and for the 15 minute observations to continue. A Brief Psychiatric Rating Scale (BPRS) and Hamilton Rating Scale (for identifying depression) were to be conducted. A urine screen was to be ordered and it was decided that contact should be made with the GP in order to understand whether Mr. Z was on any medication.[26] The Rochdale GP was contacted and it was ascertained that Mr. Z was being prescribed Ibrobrufen 400mgs TDS (three times a day) for back pain.

On this day Mr. Z was described as isolative, keeping himself to himself. He spent long periods of time in his bedroom. He remained distracted but did not appear to have any paranoid or delusional thoughts.[27]

3 August 2007. Mr. Z was reported as spending most of the day in his room. He ate well and whilst remaining isolative did not express any suicidal thoughts.[28]

4 August 2007. The Named Nurse completed a Hamilton Rating Scale and a Brief Psychiatric Rating Scale (BPRS). These were placed within the nursing clinical records. Mr. Z scored 18 (placing him within the severe depression category) on the Hamilton Rating Scale and 50 (placing him in a moderate category) on the BPRS.

On this day Mr. Z was observed as isolating himself and not wishing to interact with staff. He remained in his bedroom for most of the day. There were no signs of psychosis or suicidal ideation reported. It was recorded that Mr. Z had required medication the previous night to help him sleep.[29]

26 Medical Records PP14-15
27 Nursing Records P.37
28 Nursing Records P 37
29 Nursing Records P 38

5 August 2007. Mr. Z was observed as having no signs of psychosis or of having any suicidal thoughts. Whilst he remained in his room for most of the day he did come out to the dining room to eat his meals. Mr. Z was also reported to have slept well.[30]

6 August 2007. Mr. Z was seen by the Specialist Registrar. It was recorded in the medical notes that Mr. Z remained *"low"* and maintained the idea that people wanted to harm him. "*Nil suicidal ideas but had in past"* was noted. Mr. Z was commenced on Citalopram 20mg OD (once daily).[31]

The nursing records stated that Mr. Z *"remains facially low and isolative".* Mr. Z came out of his room for his meals but chose not to interact with the nursing staff.[32]

7 August 2007. Mr. Z was described as having slept well. In the morning Mr. Z was described as *"isolative"* however in the afternoon he was reported as coming out of his room and spending time in the ward communal areas, he was described as being *"more pleasant".* No signs of psychosis or suicidal thoughts were detected.[33]

8 August 2007. Mr. Z was reported as having slept well. It was also recorded that Mr. Z *"continues to appear facially flat, blunted affect".* Mr. Z was described as being pleasant on approach and that he would interact minimally with staff. Mr. Z spoke to a friend over the telephone, who visited the ward later that day bringing some of Mr. Z's possessions with him. No suicidal thoughts or hallucinations were detected.[34] The Specialist Registrar noted that Mr. Z's urine screen was negative.

9 August 2007. Mr. Z was seen at the ward round, the Consultant Psychiatrist, Specialist Registrar, Senior House Officer and Named Nurse were present. It was recorded that Mr. Z remained guarded and that he still maintained the belief that people were trying to poison him. Whilst Mr. Z reported that he felt better he said that people were watching him, talking about him and trying to harm him. Mr. Z was of the belief that people hated him and thought he was a spy. Mr. Z stated his belief that the future looked *"black"* and that he stayed in his room in order to protect himself. It was noted that he looked anxious and the medical

30 Nursing Records P 38
31 Medical Records P15
32 Nursing Records P 39
33 Nursing Records P39
34 Nursing Records P 40

impression was that Mr. Z had a severe depression with psychotic symptoms. The plan was to continue with the Citalopram and to commence Olanzapine 5mg once a day for a period of one week with the view of increasing it to 10 mg once a day the following week.[35]

The nursing records stated that Mr. Z spent most of the time in his room leaving only to attend to his personal hygiene and to eat his meals. He remained on 15 minute observations; however no suicidal ideation was noted to be present.[36] A member of staff from Leopold Court telephoned the ward to say that Mr. Z was now technically homeless and that whilst they would take him back at the point of his discharge, Mr. Z would need to be re-referred.

10 August 2007. The nursing notes recorded Mr. Z as remaining *"facially low, minimal interaction but pleasant on approach".* No auditory hallucinations had been observed. Mr. Z had eaten well and spent most of his time in his room reading a book.[37]

11 August 2007. Mr. Z was reported to have slept well. Mr. Z was kept on 15 minute observations even though no suicidal thoughts had been expressed and no paranoid ideas or delusions had been observed. Mr. Z was noted as being pleasant and polite, but also isolative and withdrawn. He had a small amount to eat and stayed in his room most of the day reading a book.[38]

12 August 2007. Mr. Z was reported as having slept well. However during the morning Mr. Z appeared to become distressed believing that people thought he was a spy, just as they had at Leopold Court. Mr. Z sat in the nursing office where he was reported as being tearful and appearing to respond to *"perceptual disturbance".* Mr. Z was asked if he was 'seeing things' and he replied that a *"big black man follows him around"* and that was why he sometimes hid in his wardrobe. Mr. Z did not believe that these beliefs had anything to do with him being unwell. He returned to his bedroom and refused to eat in the dining room.

In the evening, whilst no suicidal ideation appeared to be present, Mr. Z continued to be paranoid believing that other patients were coming into his bedroom.[39]

35 Medical Records PP16-17
36 Nursing Records P41
37 Nursing Records PP 41-42
38 Nursing Records P42
39 Nursing Records P 43

13 August 2007. Mr. Z remained awake throughout the night. The ward staff called the On Call Doctor during the night who prescribed prn Olanzapine 5 mg. It was noted that at this stage there were no acute concerns. However Mr. Z began to talk about his time in prison and the torture that he experienced there. He could not sleep.

Sometime in the morning, at around 11.00am -12.00 midday, the Specialist Registrar visited Mr. Z. It was recorded that Mr. Z wanted to remain in his room and that he had been distressed in the night. The plan was to continue with the antipsychotics and to encourage him to spend time out of his room.[40]

At 13.00 hours Mr. Z was described as *"facially low with minimal interaction although pleasant on approach".* Mr. Z was not noted to have had any suicidal thoughts or hallucinations. Mr. Z had slept all morning and had remained in his room for his medication and meals.[41] Mr. Z was described by a clinical witness to this Investigation as being *"distressed, he was paranoid, he was feeling unsafe".* Mr. Z was described as sitting hunched on his bed huddled against the wall for most of the afternoon shift prior to the incident occurring.[42]

This was the last entry made in the clinical notes prior to the incident which occurred at approximately 17.20 hours. The following account has been taken from witness statements, Independent Investigation interviews and clinical records made after the incident.

Account of the Incident

Mr. Z continued on 15 minute observations and had his tea in his bedroom. Mr. Z was described as being distressed, paranoid and as feeling unsafe by the Care Assistant assigned to his care on the afternoon shift. The Care Assistant reported this to the qualified staff and tried to offer Mr. Z reassurance.[43]

40 Medical Records P 18
41 Nursing Records P44
42 Witness Transcription
43 Independent Investigation Witness Transcription

Nursing Staff Account

At approximately 17.20 hours a Care Assistant on Hollingworth Ward saw Mr. Z walking away from the female lounge carrying a belt in his hand. He looked at her and said *"I've done it"* he went on to say *"I had to kill her because she called me a spy".* The Care Assistant looked into the room and saw Ms. X laying on the floor and immediately hit the panic button. At this stage Ms. X was laid on her right side, her lips were blue and her complexion was pale. The Deputy Ward Manager (Ward Sister) arrived with another Care Assistant within a few seconds.[44] The alarm raised staff from a neighbouring ward. Two nursing staff remained with Mr. Z in his room, and the rest of the nursing staff undertook a resuscitation procedure on Ms. X.

The Deputy Ward Manager (Ward Sister) called for an ambulance at 17.32 hours. A second ambulance call was made at 17.40 hours and the ambulance arrived on the ward at 17.45 hours. The police were also called and they arrived on the ward at 18.14 hours and arrested Mr. Z at 18.16 hours.

Ms. X was taken to the Accident and Emergency Department at Rochdale Infirmary at 18.06 hours where she was pronounced dead at 18.28 hours.

Account from Mr. Z

During the Criminal Justice proceedings Mr. Z made a series of statements. He told the Police that the night before the incident he had not slept well. He had sought out the nursing staff because he was scared and did not want to go back to his room. The nursing staff had reassured him and told him that they would continue to observe him every 15 minutes during the night to ensure he was safe. Mr. Z continued to tell the nurses that he believed people would come to kill him and that finally a nurse contacted a doctor and *"got me one tablet, they gave me. Even after taking that I could not sleep".*[45] Mr. Z described hearing voices shouting at him *"spy, spy, you spy, You British spy".*

Eventually Mr. Z managed to get to sleep. On waking Mr. Z explained to staff that he had heard shouting in his head. As the day progressed Mr. Z decided that he wanted to kill

44 Home office and Police Documentation File P166

45 Home office and Police Documentation File P.P 249-250

himself. He tried to use his belt but was unable to tie a knot. Mr. Z placed the belt on his bed. A nurse came to see him and said that she was worried about him and put the belt in his wardrobe. After the nurse left Mr. Z described taking the belt back out of his wardrobe, he started to try to make a rope of his sheets but it *"did not work".* At this stage Mr. Z was in a highly distressed state.[46]

At this point Mr. Z described thinking he heard someone knock on his bedroom door. He opened the door to find a lady standing there, the lady was Ms. X. Mr. Z asked her if she had knocked on the door, but she said that she did not. She walked to the female lounge and Mr. Z followed her. Mr. Z then said that he heard a very loud shout in his head saying *"strangle her, strangle her"* the voices were telling him that it was Ms. X who was calling him a spy. Mr. Z then strangled Ms. X with his belt by placing it around her neck. Mr. Z said *"and she just fainted but at that time she did not, she didn't die, I think. I told the staff".*[47]

Following telling the nursing staff that he had strangled Ms. X he was observed in his room by two nursing staff and he was unable to kill himself, so he sat down on his bed and waited for the police to arrive. He was arrested and taken into police custody at 18.16 hours.

46 Home office and Police Documentation File P.P 252-253

47 Home office and Police Documentation File P.P 254-255

11. Identification of the Thematic Issues

11.1. Thematic Issues

The Independent Investigation Team identified eighteen thematic issues that arose directly from analysing the care and treatment that Mr. Z received from the Pennine Care NHS Foundation Trust. These thematic issues are set out below.

1. **Ward Environment.** There were two points of significance here. First: the ward environment at the time of the incident was far from ideal, however the Internal Review report addressed many of these issues. The Independent Investigation Team felt that the ward environment could be further improved by making changes to the functionality of the ward. Second: there were outstanding issues regarding the delivery of services on a small site. These potentially affect the integrity of the service offered. Issues of concern were identified as currently including:

- clinical supervision and access to expert/professional advice;
- medical, psychiatric and environmental emergencies, (especially at night);
- staff training and access to library services;
- reduced multidisciplinary team provision;
- fewer opportunities for normalisation/implementation of the recovery model utilising community-based resources (e.g. maintaining networks and community-based support, being able to use community-based facilities).

2. **Diagnosis.** Mr. Z was diagnosed with depression with psychotic features. This was a reasonable diagnosis to make. However *"PTSD?"* (Post Traumatic Stress Syndrome) also appeared in the clinical record. If this condition was present then it would have exacerbated any erratic behaviour Mr. Z presented with. The potential presence of PTSD was not examined. The notion that Mr. Z had PTSD is an important one given his history and psychotic presentation. His distress was a significant part of his presentation and the impulsivity that could be expected from a person with a possible PTSD was not taken into account.

3. **Medication and Treatment.** Mr. Z was admitted onto the ward with a diagnosis of depression with psychotic features. It was decided to assess Mr. Z drug free for 48 hours. Although it is good practice for new admissions to psychiatric wards to have periods of assessment without treatment for the purpose of diagnosis, there was no justification for not providing the patient with *pro re nata (*PRN or 'as required)) medication to help him with his anxiety, distress, fear and insomnia. Mr. Z was admitted on 1 August after presenting with psychotic symptoms. Mr. Z actually went six days without medication. He was given antidepressant medication, Citalopram, six days after admission. He was not given any antipsychotic medication until 9 August, eight days after his admission. Nursing staff had to resort to calling in the duty doctor in order to manage Mr. Z's considerable distress which continued throughout his inpatient stay. Drug-free assessments have to be well structured with teams knowing what is to be assessed and how this is to be achieved.

4. **Use of the Mental Health Act (1983).** This was found to have been used appropriately. However the ward did not follow its own policy and procedure regarding its process relating to informal patients.

5. **Care Programme Approach (CPA).** No evidence exists to show that CPA had been commenced whilst Mr. Z was on Hollingworth Ward. Mr. Z was made homeless within a few days of being admitted and he would have required a high degree of input to be made ready for discharge. CPA provides for a holistic assessment and planning approach to be taken, it was not clear how this would have been managed for Mr. Z.

6. **Risk/Clinical Assessment.** There was no record of either informal or formal risk assessment being carried out by the treating Medical Team. There was also no record of any proper/thorough history taking and Mental State Examination being carried out by the medical members of the treating team. The Named Nurse conducted a sound assessment on the 1 August 2007, however there was no indication that the Medical Team benefited from this. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time. Hamilton rating scales were used on Mr. Z when the team were still uncertain whether or not he could

understand English. The scale was rendered unreliable as a psychometric tool for use with Mr. Z because of his cultural background and potential linguistic limitations.

7. **Referral, Admission and Handover Processes.** This appears to have been conducted in a competent manner.

8. **Cultural Diversity and the Care of Asylum Seekers.** Trust clinicians did not take into account the significant cultural diversity issues raised when providing care and treatment for individuals such as Mr. Z. Neither was best practice guidance considered when providing care and treatment for a person who was an asylum seeker.

9. **Service User Involvement in Care Planning and Treatment.** There was a degree of uncertainty within the treating clinical team whether or not Mr. Z could understand English. This factor was given as a reason why his assessment had not been undertaken in the usual way. Mr. Z was an asylum seeker who had experienced a traumatic sequence of life events. These were not taken into account in an appropriate manner. Throughout Mr. Z's time on Hollingworth Ward minimal effort appears to have been made to engage him in his care and treatment and to build up a therapeutic relationship with him. Had more time been spent with him it would have become apparent that Mr. Z had a competent understanding of the English language and that this did not present a barrier to communication.

10. **Documentation and Professional Communication.** Medical inputs in this area were deemed to be poor. Doctors did not write comprehensive notes in the clinical record, and neither did they routinely read through clinical records prior to ward rounds. There was an assumption that Mr. Z was admitted onto the ward with little information about him being known, this was not correct. There was reliance by doctors on nursing staff to conduct assessments and a culture of not recording what was discussed. Doctors felt that had they known more about Mr. Z they would have acted differently, this information was available to them, but remained unread and was not taken into account. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time.

11. **Overall Clinical Management of the Case.** There did not appear to have been multidisciplinary team working on the ward in any meaningful sense. Nursing and medical assessment and care and treatment planning appear to have been conducted separately with no process in place to bring them together. The ward round did not benefit from a proper multidisciplinary input with the Named Nurse main function appearing to be that of patient escort. This situation was exacerbated by the lack of an integrated clinical record. As a consequence Medical Staff did not read the nursing notes and in effect based care and treatment decisions on their own observations only. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time. After a 12 day period on the ward Mr. Z was still not in receipt of an appropriate care and treatment plan based on a sound multidisciplinary assessment.

12. **Resuscitation Process.** The resuscitation process, on the whole, was managed well. The main point of learning was in the summoning of the ambulance. This did not work smoothly with the ambulance call centre being given the details for a 'green' alert (non-urgent) rather than for a 'purple' alert (urgent). The ensuing delay was due to this factor. There was also a degree of confusion regarding 999 and 444 procedures for summoning emergency support.

13. **Clinical Supervision.** Supervision did not happen on a regular basis. However this did not affect directly the outcome of the case.

14. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** The clinical team did not adhere fully to policy and procedure. This was a particular issue with the medical staff. This was particularly noticeable in the areas of:

- risk assessment;
- record keeping;
- national Post Traumatic Stress Disorder Guidelines;
- asylum seeker clinical management.

15. **Organisational Change.** The care and treatment that Mr. Z received was given in the context of ongoing organisational change. This change in itself did not affect clinical practice in a negative manner. However clinical record systems and multidisciplinary

working have been identified by the Independent Investigation Team as requiring significant redesign and this is currently being addressed as part of the Trust's ongoing organisational change strategy.

16. **Clinical Governance and Performance**. Several issues were noted that would indicate clinical governance failed to operate coherently on the unit at the time of the incident. This was evidenced by the lack of integrated records, multidisciplinary team working and the failure to provide the basic building blocks of care, e.g. assessment, psychiatric history, implementation of care plans, teaching and training etc. The Trust audit cycle may not have been robust enough to detect shortfalls in practice. However in 2010/2011 it was found that clinical governance practices were of a notable practice standard.

17. **The Care and Treatment of Ms. X.** The Independent Investigation Team found that the care and treatment of Ms. X was appropriate and did not contribute in any way to her death.

18. **Internal Review.** The internal review was competently prepared. However it is not unusual for an independent investigation with a wider ranging set of terms of reference to make additional findings. This has occurred in this case.

12. Further Exploration and Identification of Contributory Factors and Service Issues

In its simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)
- original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. If it was applied to Mr. Z it would look like this:

- Mr. Z killed Ms. X (ask why?)
- because his delusional beliefs and auditory hallucinations instructed him to (ask why?)
- because Mr. Z was suffering from the symptoms of a psychotic mental illness = root cause.

It is possible to say these symptoms of a psychotic mental illness were the underlying root cause to Mr. Z's decision to kill Ms. X. However it was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Z and his partially treated and deteriorating mental state. When examining the effectiveness of care and treatment it is reasonable to assume the following:

- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;
- risk management and treatment plans can reasonably be expected to reduce risk and to improve mental health.

His Honour Judge Gilbert Queen's Counsel on sentencing Mr. Z said *"in a modern society those who suffer from the affliction of mental illness or disorder must be treated with the*

same sympathy and care as attends those suffering from any other illness…I am satisfied on the evidence that you were suffering from paranoid schizophrenia in a particularly severe form. It led you to kill your victim".[48] This Investigation found a direct causal link between the care and treatment that Mr. Z received and his partially treated and deteriorating mental state. The sentencing Judge made the causal link between his mental state and the death of Ms. X.

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. contributory (both influencing and causal) and service issue factors.

In the interests of clarity each thematic issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Contributory factors can be identified as either being 'influencing' or 'causal'.

Causal Factors. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to manage Mr. Z effectively and that this as a consequence impacted directly upon his partially treated and deteriorating mental state.

48 Court Transcription 27 April 2008 P1

Influencing Factors. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a contribution to the breakdown of Mr. Z's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

Service Issue. The term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Ms. X need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1. Pennine Care NHS Foundation Trust Findings Relating to the Care and Treatment of Mr. Z

The findings in this chapter analyse principally the care and treatment given to Mr. Z by the Pennine Care NHS Foundation Trust between the 1 August and the 13 August 2007. The care and treatment given to Ms. X is examined in subsection 12.2.

This chapter is presented in a total of 16 subsections. Subsection 12.1.1. addresses the ward context in which Mr. Z and Ms. X received their care and treatment. Subsections 12.1.2. - 12.1.11. address diagnostic, medication and treatment issues for Mr. Z. Subsections 12.1.12 to 12.1.15. address key Trust governance systems and processes. Subsection 12.2. examines the care and treatment given to Ms. X.

12.1.1. Ward Environment

12.1.1.1. Context

The Ward in August 2007

The Independent Investigation Team acknowledges gratefully the work of the Internal Review Team (internal investigation team) with regards to describing the Hollingworth Ward environment as it existed in August 2007. A three-year interval has occurred between the incident and the beginning of this Investigation. The Trust has put into place many changes and it would have been no easy task to understand the 2007 ward context without the detailed work of the Internal Review Team which is set out directly below in this context section.

At the time of the incident Hollingworth Ward was a 16 bedded unit for the assessment of adults of working age with acute mental health problems. The ward provided beds for both male and female patients. The average length of stay was 24 days, and in August 2007 the ward was occupied fully and had a number of service users who had additional needs including one who was severely disturbed and another who had physical mobility needs.

Hollingworth Ward was, and still is, located in a modern building on the Birch Hill Hospital site which was originally built to provide day care services. The ward was not purpose built for the care and treatment of psychiatric inpatients. However in 2005/2006 the ward had been refurbished and in 2007 comprised an L shaped layout with communal areas and separate male and female sleeping and bathroom areas (for a map of the ward please see Appendix Three). Service users had their own side rooms and the female-only area was down one end of a corridor which was not a thoroughfare.

At the time of the incident there were three bedrooms (1, 9 and 8) at the beginning of the female-only corridor that were sometimes allocated to male patients when the need arose. Mr. Z's side room was number 9, which was two doors down from the designated female-only lounge. The bedroom doors were solid and did not have viewing panels set within them which made observing patients a problem, particularly at night.

Alarm systems were fob operated and there were often difficulties in hearing alarms on certain parts of the ward. The main entrance to the ward was locked and patient access and

exit was controlled by the nursing staff. On admission Informal patients were required to sign a form stating that they both understood and accepted that this was the case for safety reasons.

There were activities available to the service users on the ward, however these were restricted due to the availability of staff. At the time of the incident there was no occupational therapy provision.

Mixed-Sex Accommodation

Whilst every effort was made on Hollingworth Ward to segregate the sexes it was in effect a mixed-sex ward.

In January 2009, the then Secretary of State for Health, Alan Johnson, said *"the message is clear - the NHS has taken great strides in reducing mixed-sex accommodation over the last 12 years but now it must eliminate it altogether other than where clinically necessary."* Following this announcement £100 million investment was identified to support the initiative.

MIND, a national mental health charity, had this to say about the 2009 government plans to end mixed-sex wards:

"We warmly welcome the £100m investment announced today by the Government towards finally abolishing mixed-sex wards. For too long now vulnerable mental health inpatients have been put in mixed-ward environments where they have no privacy and are made to feel uncomfortable and even unsafe. Over three quarters of female mental health inpatients were treated in mixed-sex accommodation last year; this is an unacceptable state of affairs and it is only right that this scandal is at last being addressed." [49] MIND also stated that, "*the latest Healthcare Commission 'Count Me In' census, which monitors the number of inpatients in mental health hospitals in England and Wales, shows that 68% of mental health inpatients are still being housed on mixed-sex wards. Women were even less likely to be given single-sex accommodation than men, with 78% treated on a mixed-sex ward in comparison to 61% of men."*

49 http://www.mind.org.uk/news/232_justice_at_last_on_mixed_sex_wards_scandal

The current Secretary of State for Health, Andrew Lansley, stated in August 2010 that *"mixed-sex wards will be abolished by the end of the year, reporting of breaches of rules on mixed-sex accommodation will be introduced from the start of next year. Any failing trusts will be fined."*[50]

Defining what constitutes a mixed-sex ward, or mixed-sex accommodation can at times appear to be a question of semantics. A mixed-sex *ward* that admits both male and female patients does not necessarily mean that *accommodation* is classified as being mixed sex. For accommodation to be classified as being 'single-sex appropriate' clinical environments have to provide adequate arrangements that ensure the dignity and privacy of patients is safeguarded. This means that on mixed-sex wards sleeping areas, washrooms and toilets have to be strictly segregated.

In an acute general-ward context (for the physically ill), even though it may be mixed-sex, patients will be cared for throughout their stay in single-sex accommodation, e.g. single-sex dormitories with single-sex bathroom facilities. Whilst this same arrangement is also in place for mental health inpatient wards, there are more complex issues at play. There are some fundamental differences in that psychiatric patients are usually mobile and men and women mix in communal areas. In February 2008 the Royal College of Nursing Mental Health Forum, when reviewing mixed-sex wards, gave the following example to point out the challenges *"people with mental health problems often become disinhibited,…If you have a predatory male, or vice versa, it may put people at risk."* Basically psychiatric wards with both male and female patients, regardless of single-sex accommodation provision, will always present many levels of risk and require compromises to be made. Small wards within small hospital sites will come under even greater pressure when appropriately segregating the sexes due to environmental limitations and competing ongoing patient management factors.

The Internal Review Team described the dilemma well: *"there is widespread confusion and misinterpretation of the term 'mixed-sex accommodation'. It must be assumed that service users requiring admission to an Acute Mental Health ward are experiencing significant mental health problems which can result in them being vulnerable and at risk or a risk to others. The judgement and decision making of those individuals on admission is likely to be*

50 http://www.psychminded.co.uk

impaired and the service has a duty of care to protect vulnerable patients from the behavioural consequences of their own mental illness and the mental health condition of others in the same environment. Disinhibition or being unusually passive, or emotional disturbance, can lead to risky and at times reckless behaviour. A caring environment promoting dignity and respect is a safe one. Ensuring safety helps to promote recovery and ultimately improves self respect and well being." [51]

Over the past twenty years psychiatric inpatient facilities have been, in general, provided on small hospital campus sites. Inpatient bed numbers have also reduced in order to focus on the care in the community model. This leaves mental health Trusts across the country with an ever-present challenge when providing safe and appropriate accommodation for service users. The small site provision of specialist secondary care services can often create a reduced economy of scale that can give rise to both the quality and safety of services being compromised. These challenges do not comprise the mixed-sex issue alone, but also include those of:

- integrity of service (e.g. effective evidence-based service provision by a full multidisciplinary team);
- the adequate management of medical, psychiatric and environmental emergencies (e.g. response to cardiac arrest, violence and aggression, fire);
- quality of service user experience (e.g. access to fresh air and leisure activities).

12.1.1.2. Findings

Ward Environment and Service Delivery in 2007

At the time of the incident patients were admitted from a number of referral sources and were admitted to any one of five principal Consultant Psychiatrist Teams. At the point of admission a Named Nurse and two Associate Nurses would be allocated to each patient.

5.6 Consultant Psychiatrists worked on the ward. Each medical team comprised a Consultant Psychiatrist and a Junior Doctor. In addition several of the Consultants also had a Specialist Registrar working with them. Patients were admitted to Hollingworth Ward as part of a pooled bed arrangement. Each Consultant Psychiatrist had a weekly timetable that included:

- 7.5 sessions towards direct patient care;

51 Internal Review P 44

- 2.5 sessions toward supporting programmed activities which included administrative time, supervision and audit.

The Nursing Team comprised:

- 1 x Ward Manager who provided leadership to the nursing team and ensured that the ward ran effectively;
- 1 x Charge Nurse;
- 1 x Ward Sister;
- 9 x Staff Nurses;
- 2 x Trainee Assistant Practitioners;
- 6 x Care Assistants;
- 1 x Ward Clerk;
- 2 x Social Care Support Workers.

The Ward Manager was supernumerary and the nursing establishment was designed to manage the ward at full occupancy with the ability to absorb the workforce requirements of having one patient on 1:1 observations. If the need for additional staff was identified then there was provision for nursing staff to be supplied either from a bank or agency. On the day of the incident the staffing levels were:

Table Four

Shift	Time	Staffing Numbers per Shift
Early	07.30 - 14.30	5 (plus 1 Care Assistant 9-5 to facilitate activities)
Late	13.30 - 21.45	5
Night	21.30 - 07.45	4

The ward environment was challenging in that it had not been designed with the inpatient care and treatment of the mentally ill in mind. For example, the ward did not lend itself to the observation of patients as sight lines were poor and multiple ‘blind spots’ existed. In addition the ward space was small and offered little room for manoeuvre in the separation and management of patients who were either vulnerable or unable to cope with a high-stimulus environment. Another important factor was the added complication of having to treat both male and female patients in a clinical space that was limited in size and therefore the

requirements of sex segregation had to compete alongside those of other general patient management issues.

Ward Environment and Service Delivery in 2010/2011

Following the incident a significant number of environmental changes were made to the ward. During the initial refurbishment that took place in 2005/2006 the clinical staff had not been consulted about the proposed ward environment. On reflection it was felt that had clinical mangers been involved at this stage then the ward would have been designed in a more efficient and fit for purpose manner. The clinical staff were engaged fully in the 2007/2008 alterations that took place following the incident. These included:

- placing observation panels in side-room doors;
- re-designation of female-only beds with electronic-card control access to female side-room areas;
- review of the ward-alarm system;
- creation of safeguarding children-appropriate family room visiting facilities;
- creation of a multifaith room;
- engagement of a minimum of two security guards at night, with facility for a third to be present if required.

Current Safety and Integrity of Service

Regardless of the relatively recent environmental changes that have been made Hollingworth Ward still retains the challenges of a service provided from a small hospital site. The Independent Investigation Team assessed the ward using a safety review proforma (Appendix Two). This standards proforma was utilised in order to understand Hollingworth Ward services within a national best practice context. The proforma was developed utilising the Accreditation for Acute Inpatient Health Services (AIMS; Royal College of Psychiatry), the Care Services Improvement Partnership (CSIP) standards, *Onwards and Upwards*, the Mental Health Policy Implementation Guide, and the Dignity Challenge standards. Only those standards that had a specific relevance to the workings of a small site were used. The standards were not intended to form a general service review, but were selected to anchor evidence collection within national expectations and to adhere to the Independent Investigation commission brief.

The proforma that the Independent Investigation used contained 99 standards. These standards covered the following headings:

1. management and governance of the ward, to include;
    - clinical policies;
    - assessment processes;
    - care planning;
    - clinical interventions;
2. facilities available to the service user;
3. service user issues;
4. ward environment, to include;
    - dignity and privacy;
    - safety;
    - facilities;
5. families and carers;
6. staffing and staff support;
7. health and safety.

Out of the 95 standards three were found to not be applicable to the site. 70 standards were met in full. 19 standards were partially met (between 50-80%). Five standards were not met. HASCAS, the Health and Social Care Advisory Service, conduct safety reviews of this kind on a regular basis and would like to state here that these results represent what would be found normally on a small hospital site that was considered to be working well.

Environmental Issues

The Trust has been able to manage the environmental difficulties posed by providing psychiatric inpatient services on a small site well. Following the death of Ms. X significant changes were made to the ward environment in order to ensure sex segregation, observation, and security issues were addressed. However the ward will always retain the risks associated with providing acute inpatient psychiatric services to relatively small numbers of patients with highly variable conditions and clinical management challenges. Small sites cannot always provide the required economy of scale to ensure that safe, effective and timely alternatives can be offered to all service users as required. That being said, there are currently two inpatient acute admission wards for adults of working age on the Birch Hill Hospital site

and future reconfiguration may provide an opportunity to revisit the hospital 'footprint' regarding sex segregation and/or the management of challenging or violent behaviours.

Integrity of Service Issues

Hollingworth Ward currently operates the Productive Mental Health Ward and the STAR Wards initiatives to good effect. The Trust and the ward staff are to be commended in ensuring that everything within their gift has been considered in the safe and effective delivery of inpatient services. This is reflected in the high number of standards that were assessed as being met fully during the Independent Investigation Review. (Please see Appendix Two). NHS Heywood, Middleton and Rochdale (the Primary Care Trust) initially funded the implementation of the Productive Ward and have found vast improvements to the service since this time.

The Productive Mental Health Ward focuses upon:

- improved patient experience;
- improved efficiency of care;
- improved patient safety and reliability of care;
- improved staff wellbeing.

The success of the initiative requires:

- releasing time to care and to become more efficient by the prioritisation of work;
- accessing and understanding clinical governance data about performance;
- sound clinical leadership;
- effective role modelling;

The Productive Ward and Star Wards programmes have significantly decreased:

- assaults to both patients and staff;
- absconsion;
- self harm;
- all other kinds of violence;
- medication errors;
- Mental Health Act errors;
- incidents (of any kind).

Hollingworth Ward is a vibrant clinical environment that provides a holistic assessment, care and treatment approach. The ward is managed in a well-organised manner that allows for a high level of good quality clinical engagement with patients to take place. The Independent Investigation Team, when visiting the ward, saw evidence that Trust aspiration was matched by the reality of the service delivery.

However there were a total of 24 standards that were either not entirely met or not met at all. These standards focused mainly upon the quality and range of clinical interventions available to service users. The Trust is not funded fully at the present time to provide a multidisciplinary team approach to Hollingworth Ward. There is no access to either psychology or occupational therapy services. This is not an uncommon feature of inpatient service provision on a small site. Whilst this does not compromise safety, it does compromise the integrity of the service being offered to the acutely mentally ill patient and can affect both short term wellbeing and long term recovery.

Safety of Service Issues

A major factor in the maintenance of safety on a small site is the ongoing management of environmental, medical and psychiatric emergencies over a 24 hour period, seven days a week, 365 days of the year. It was evident to the Independent Investigation Team that the Birch Hill Site staff are appropriately trained and are available in sufficient numbers during the day to manage emergency situations. Staff also have access to appropriate and evidence-based internal policies and procedures for the management of emergencies.

As has been mentioned above, there are two inpatient acute wards on the Birch Hill site providing inpatient facilities for 40 adults of working age. The site also comprises:

- a low secure 44 bedded unit;
- an Outpatient Department;
- Child and Adolescent Psychiatry (day) Services;
- a psychological therapies clinic;
- a memory clinic;
- kitchen, portering, domestic and facilities services;
- Crisis Resolution and Home Treatment Team base;
- management offices.

During the day there is estimated to be approximately 100 whole time equivalent members of staff on the site. This figure is an approximate estimate taken from the establishment figures; shift working, annual leave, training, service replacement issues etc. have been taken into account. During the night the estimated whole time equivalent numbers of personnel on the site is approximately 24.

The presence of security guards 'around the clock' serves to ensure that an additional resource is made freely available to clinical teams as and when it is required. However there were two outstanding safety issues identified:

- Medical cover during the night is currently shared with the Accident and Emergency Department at the Rochdale Infirmary. This means that medical cover is not always present on site out of hours to support a crisis situation as the on call doctor may not be able to answer an emergency bleep immediately.
- There is no seclusion facility at present on the Birch Hill site. At the current time violent patients have to be nursed on the ward. There can be significant delays, ranging from a few hours to a few days, when transferring patients with this kind of behaviour to an intensive care environment.
- In common with other small units across the country all emergency situations on site would be managed *in extremis* by calling the appropriate emergency service. The ward staff could not say whether or not there were any formally agreed protocols with the emergency services with regard to the management of crisis situations.

12.1.1.3. Conclusions

Ward Environment and Service Delivery in 2007

Ward Environment

In 2007, at the time of the incident, the Hollingworth Ward environment presented challenges to the nursing staff regarding the management, appropriate segregation and observation of patients. Following the incident the Trust made a series of appropriate and practical changes to the ward in order to mitigate against any further risks.

The issue regarding mixed-sex wards/accommodation is a more pertinent one. Had Ms. X not been nursed on a mixed-sex ward then she would not have been subject to a violent act at the hands of Mr. Z. The close proximity of patients with varying diagnoses and of variable

vulnerability will always create an ongoing clinical management challenge. Overlaying the complexities of mixed-sex service provision exacerbates the situation. Ms. X was elderly, small and had physical ill health problems. Whilst Mr. Z could have attacked a more physically robust individual, who could have survived the assault, he did not. Mr. Z attacked Ms. X who was frail and quickly succumbed to her injuries. Unfortunately this particular incident is exactly the kind that mental health charities and the Royal Colleges have been seeking to prevent for some time when calling for the abolition of mixed-sex inpatient provision. The likelihood of harm is increased when too many variables: age, sex, diagnoses, behaviour, insight, and vulnerability, are placed together under one roof. It could be argued that had Ms. X been attacked by an aggressive female patient she would have been equally vulnerable and the outcome could have been the same. It is not always possible to assign direct causality to a single factor when analysing a serious untoward incident of this kind. The act of homicide in general does not lend itself to gender specification. Perpetrators and victims can be either male or female. Therefore it cannot be stated that a mixed-sex environment alone was responsible. The Independent Investigation Team concludes that whilst a mixed-sex ward environment may have made an indirect contribution to the death of Ms. X, it did not cause it.

Safety of Service on a Small Site

The Independent Investigation Team has not been able to assess how well general safety issues were addressed on the site in 2007. The Internal Review Team did not incorporate this aspect into its terms of reference. The current service provision has a number of new managers and they found it difficult to explain how safety issues were managed prior to their tenure. Following the incident the Health and Safety Executive (HSE) identified that the Trust needed to consider the review of its management arrangements and risk mitigation processes for potential incidents of violence and aggression. The HSE also identified the need to review the alarm systems, to ensure that the visual access to side rooms was improved, and to provide swipe-card access by gender to the bedroom areas. No issues were identified that had a direct contributory or causal bearing on the death of Ms. X.

Integrity of Service Offered on a Small Site

At the time of the incident there was little in the way of patient-centred engagement activities available to service users on the ward. It would appear that whilst the ward nursing establishment was sufficient to ensure the day-to-day safety of the service, the

multidisciplinary skill mix could not ensure the integrity of the service in that a full range of evidence-based interventions was not available in accordance with either the National Institute for Health and Clinical Excellence or the National Policy Implementation Guidelines. The Internal Review mentioned that following the 2005/2006 refurbishment of Hollingworth Ward the commissioner of service (NHS Heywood, Middleton and Rochdale) was presented by the Trust with a revised multidisciplinary skill mix review which required additional investment. No additional funding was allocated at this time. The Trust was able to fund the required increases to the nursing establishment through efficiency savings, however multidisciplinary skills inputs could not be made available to the ward. Subsections 12.1.2.-12.1.11. below establish clearly a direct contributory relationship between the failure to provide either an engagement programme or a multidisciplinary team input to the care and treatment of Mr. Z and the continued deterioration of his mental state. NHS Heywood, Middleton and Rochdale (who was not the lead commissioner at the time of the incident) contributed the following view regarding the funded establishment. *"At the time of the incident there was no occupational therapy provision. When creating Hollingworth Ward the mental health Trust decided to discontinue the day hospital and occupational therapy team as part of its recovery planning".*[52]

Current Safety and Integrity of Service 2010/2011

Ward Environment

The Trust has made every effort to ensure that the safety, privacy and dignity of patients is achieved. It was evident to the Independent Investigation Team that the organisation had very sensibly considered safety issues alongside those of privacy and dignity and had worked to ensure these essential cornerstones of care were in place as robustly as possible given the footprint of the ward.

At the present time the only possible change that could be considered is the removal of the nurses' station that is positioned off centre to the corridors which ensures that visual lines of observation cannot be maintained. This nurses' station is not used at the current time and takes up a considerable amount of space in the centre of the ward. There is what can be considered the 'golden triangle of care'. This golden triangle comprises:

- safety;

52 PCT factual accuracy commentary

- privacy and dignity;
- therapy and treatment.[53]

Most modern facilities for inpatient psychiatric placement are able to provide for the safety and privacy and dignity parts of the golden triangle. However space is usually of a premium and wards cannot often provide for an appropriate level of therapeutic and treatment space. This can lead to service users having to conform to the constraints of a clinical area that can afford only limited activities. Whilst the Independent Investigation Team acknowledges that there are activities rooms (both on the ward and on the site) where patients can undertake a wide range of leisure and therapeutic activities, these rooms, when in use, require a high level of staff input and observation which is not always possible. It was noted that if the nurses' station was removed it could be replaced by a comfortable seating area which would facilitate social interaction in the heart of the ward within a space that was easy to observe and could be used to encourage service users to participate in engagement activities.

Safety of Service on a Small Site

The ward retains a degree of risk with regard to environmental, medical, and psychiatric emergencies, in common with other inpatient service provision on small sites. This degree of risk is raised during the night. The Independent Investigation Team noted that during the day there were sufficient numbers to manage most kinds of emergencies, and that although the staffing numbers were reduced to 24 at night, this represented a viable number of people that could be called upon to manage emergency situations.

The Independent Investigation Team would like to make the observation that there was a poor sense of 'site awareness' across the Birch Hill Hospital provision in that each service worked to some extent in a 'silo.' The Independent Investigation Team also heard that emergency procedures were mostly of the informal rather than of the formal kind with regard to utilising the emergency services. This is something that can be remedied by a revision of the Birch Hill Hospital emergency procedures, this would be of particular current relevance as the new Low Secure Unit is now located on the site and provides an additional facility and opportunity to understand the totality of the site resource.

53 A. Johnstone. Mental Health Review.

To summarise. The site maintains a viable critical mass of staff, seven days of the week and 52 weeks of the year, during both the day and the night. It would be sensible, now that the new Low Secure Unit is on the site, to review general site awareness and to ensure that emergency procedures are agreed formally with each of the emergency services.

Integrity of Service Offered on a Small Site

The integrity of service incorporates the quality of the evidence-based provision made available to the service users receiving their care and treatment in an inpatient facility. It would appear that a full multidisciplinary team comprising occupational therapy and psychology provision is still not achieved for the services on the Birch Hill site. At the present time ward nursing staff focus upon trying to provide leisure activities and psychological therapy approaches. However this cannot be assessed as providing a suitable range of evidence-based service provision in line with the National Institute of Health and Clinical Excellence (NICE) Guidance in the treatment of major psychiatric illnesses such as schizophrenia.

Summary

Present Day

The Independent Investigation Team found that, at the time of writing this report, Hollingworth Ward, whilst having to contend with certain challenges (as set out above), provided an environment that was safe and delivered services in a manner that ensured privacy and dignity. Consideration currently needs to be given to improving the access to a comprehensive range of evidence-based services and to ensuring the review of formal emergency procedures with particular regard to out of hours arrangements.

At the Time of the Incident

It was the conclusion of the Independent Investigation Team that the ward environment *per se* was not a direct causal factor in the death of Ms. X. It was also the conclusion of the Independent Investigation Team that the emergency response procedures in place at the time were satisfactory, although confused (please see resuscitation subsection below) and made no direct causal contribution to the death of Ms. X. That being said, the ward environment was difficult to observe and male patients (which at the time included Mr. Z) had side rooms that impinged upon the space set aside for the use of female patients. The incident occurred in the female lounge which at the time was located (and remains currently) in a place that was

difficult to observe, and was adjacent to side rooms being used by male patients. The isolation of the female lounge and the difficulty in observing this space was made more problematic by:

- placing Mr. Z, who was extremely disturbed, in a side room in this part of the ward;
- regular occurrences on the ward such as mealtimes, medication rounds and ward rounds, when staff were required to be concentrated in different parts of the ward;
- the adjacent location of spaces designated for both leisure activities (which could generate noise) and sleep and personal activities (which required peace and quiet).

It would appear that a 'Swiss Cheese Model' of issues all came together at the same time and these in combination contributed to the death of Ms. X. The 'Swiss Cheese Model' describes a situation when:

"every step in a process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese. Consider the holes to be opportunities for a process to fail, and each of the slices as 'defensive layers' in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught. Each layer is a defence against potential error impacting the outcome… For a catastrophic error to occur, the holes need to align for each step in the process allowing all defences to be defeated and resulting in an error."[54]

The series of situations that arose at the same time at the point of Ms. X's fatal attack came together to contribute to her death. The question is, did these circumstances represent an inherently flawed system? The Pennine Care NHS Foundation Trust, together with every other Mental Health Trust in the country, has to manage the interaction of all of these factors (or those of a similar kind) on each of their wards on a daily basis. On the 13 August 2007 all of these factors came together and made a significant contribution to the death of Ms. X.

It would not be realistic to state here that a similar environment-based situation could never occur again. However the Pennine Care NHS Foundation Trust has worked to ensure the risk of a similar occurrence from happening in the future has been mitigated against. It was the conclusion of the Independent Investigation Team that Hollingworth Ward did not, and does not, run with an inherently flawed system with regards to environmental factors and that

54 http://patientsafetyed.duhs.duke.edu/module_e/swiss_cheese.html

other circumstances, which will be explored below, also played a significant part in the death of Ms. X.

- ***Contributory Factor Number 1 (Influencing). Environmental factors came together on the 13 August 2007 in such a way that they contributed to the attack on Ms. X occurring and also going undetected.***

12.1.2. Diagnosis

The Independent Investigation Team would like to note that the diagnoses that are considered below are based on what the treating clinical team knew about Mr. Z between the 1 and 13 August 2007. The diagnosis of paranoid schizophrenia, which was later assigned to Mr. Z at Ashworth Hospital, is not considered here.

12.1.2.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs, symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10^{th} revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

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Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

Background Information

Mr. Z arrived onto Hollingworth Ward with an initial diagnosis of psychotic depression. *"?psychotic depression/PTSD"* was written in the nursing notes. Diagnostic criteria for both psychotic depression and Post Traumatic Stress Disorder (PTSD) are set out below for the benefit of the lay reader.

Psychotic Depression

The World Health ICD 10 criteria for psychotic depression diagnostic guidelines state that:

"…delusions, hallucinations, or depressive stupor are present. The delusions usually involve ideas of sin, poverty, or imminent disasters, responsibility for which may be assumed by the patient. Auditory or olfactory hallucinations are usually of defamatory or accusatory voices or of rotting filth or decomposing flesh. Severe psychomotor retardation may progress to stupor. If required, delusions or hallucinations may be specified as mood-congruent or mood-incongruent."

Differential Diagnosis

"Depressive stupor must be differentiated from catatonic schizophrenia, from dissociative stupor, and from organic forms of stupor. This category should be used only for single episodes of severe depression with psychotic symptoms; for further episodes a subcategory of recurrent depressive disorder should be used."

Includes:

"…single episodes of major depression with psychotic symptoms, psychotic depression, psychogenic depressive psychosis, reactive depressive psychosis."

Post Traumatic Stress Disorder (PTSD)

The National Institute for Health and Clinical Excellence (NICE) quick reference guide for Post Traumatic Stress Disorder states that:

"*PTSD can develop in people of any age following a stressful event or situation of an exceptionally or catastrophic nature...symptoms often develop immediately after the traumatic event but the onset of symptoms may be delayed in some people (less than 15%)... Assessment can present significant challenges as many people avoid talking about their problems."*[55]

The NICE quick reference guide lists the following symptoms associated with PTSD:

- *"Re-experiencing – flashbacks, nightmares*
- *Avoidance - avoiding people, situations or circumstances associated with the event*
- *Hyperarousal - hypervigilence for threat, sleep problems and irritability*
- *Emotional numbing-lack of ability to experience feeling*
- *Depression*
- *Drug or alcohol misuse*
- *Anger*
- *Unexplained physical symptoms"*[56]

The NICE quick reference guide recommends the following action be taken:

- *"Assessment should be comprehensive and should include a risk assessment, assessment of physical, psychological and social needs*
- *Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment*
- *Provide practical advice to enable people with PTSD to access appropriate information and services for the range of emotional response that may develop*
- *Identify the need for social support and advocate for the meeting of this need*
- *Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers*
- *Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions"*[57]

55. National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26 P 5

56 National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26 P6

Additional recommendations include:

- ensure sufferers understand the emotional reactions and symptoms that may occur;
- respond appropriately if a PTSD sufferer avoids treatment;
- keep technical language to a minimum;
- only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed;
- ensure treatment is delivered by competent individuals;
- where depression is present consider treating the PTSD first, unless the depression is severe;
- prioritise any high risk of suicide or risk of harming others.

Other recommendations from the NICE guidance suggest avoiding single sessions that focus on the traumatic incident. Psychological therapy is the treatment of choice, delivered once a week by the same person. Several sessions may be required in order to build up a therapeutic relationship based on trust prior to traumatic events being discussed. Drugs should not be offered as a routine first-line treatment for adult PTSD sufferers unless the patient prefers not to engage in trauma-focused psychological therapy.

At the point of Mr. Z's admission to Hollingworth Ward on the 1 August 2007 he had been identified, by the clinicians who assessed him, with the symptoms of both psychotic depression and PTSD.

12.1.2.2. Findings

Diagnosis at the Point of Admission

On the 1 August 2007 Mr. Z was seen by the On Call Psychiatrist at the Rochdale Infirmary. The Psychiatrist recorded that Mr. Z was isolating himself and not coming out of his room for days on end for fear of people wanting to harm him. Mr. Z had not been eating properly, was caring for himself poorly and could not sleep. Mr. Z appeared to be dishevelled and the Mental State Examination documentation described him as being tearful and as having a flat expression accompanied by some retardation of gestures, he felt that there was no point to his future. Mr. Z exhibited delusional beliefs about people calling him a spy and trying to poison

57 National Institute for Health and Clinical Excellence, Quick reference Guide, *Post traumatic Stress Disorder; the management of PTSD in adults and children in primary and secondary care.* March 26. PP. 8-10

him, he also stated that he had no choice but to either kill himself or *"them"*. Whilst Mr. Z believed himself to be well, and had little insight into his situation, he agreed to be admitted into hospital as an informal patient.[58] The initial impression was that Mr. Z had a psychotic depression.

Prior to his assessment at the Rochdale Infirmary on the 1 August 2007 Mr. Z had given an account to his Rochdale-based GP of not being able to sleep, of having nightmares and of experiencing flashbacks to the time of his imprisonment and torture in Ethiopia. The GP recorded that a Psychology referral was indicated (an appropriate evidence-based intervention for PTSD). It was evident from the On Call Psychiatrist's records, and those made by the allocated Named Nurse on Hollingworth Ward, that Mr. Z had a history of being a political prisoner, had nightmares and flashback experiences regarding his time in prison and the torture he was subject to there.[59] It was also recorded that Mr. Z had isolated himself and had thoughts of committing suicide by hanging.

On admission to Hollingworth Ward Mr. Z had an initial diagnosis of psychotic depression. An entry made in the nursing notes recorded *"?psychotic depression/PTSD"*.[60] It remains unclear to the Independent Investigation Team whether any discussion took place between the admitting Named Nurse and the On Call Psychiatrist with regards to the consideration of PTSD. It is also unclear who made the suggestion of Post Traumatic Stress Disorder (PTSD), or what criteria were used to reach this initial diagnosis. However it would appear that by this stage the GP, the On Call Psychiatrist and the Named Nurse had all considered the possibility that Mr. Z was experiencing some kind of post trauma issue.

Diagnosis Following Admission to the Ward

Mr. Z was seen at the ward round on the 2 August 2007, the day after his admission. It was noted that Mr. Z appeared to be anxious, but presented with a flat affect. It was also recorded that Mr. Z had been isolating himself, had active thoughts of hanging himself, and had been tortured in Ethiopia. Mr. Z's delusional ideas about people wanting to harm him and poison his food were discussed. Nothing was recorded in the medical record to suggest that either

58 Medical Records PP 8-12
59 Nursing Records PP 13-16
60 Nursing Records P14

psychotic depression or PTSD was considered or discussed at this stage, and no diagnostic formulation of any kind was made.[61]

Mr. Z was seen on the ward on 6 August 2007 by the Specialist Registrar. He noted that Mr. Z had scored 18 on the Hamilton Depression Rating Scale and 50 on the Psychiatric Brief Rating Scale (these assessments had been conducted by the Named Nurse on the 4 August). Little was written in the medical notes on this day, but it would appear that Mr. Z's presentation remained unaltered. He was prescribed Citalopram 20mg once a day, presumably to treat depression.[62]

On the 9 August 2007 Mr. Z was seen again at ward round. On this day it was noted that he retained his paranoid ideas about people wanting to harm him and that he felt hopeless about the future. It was recorded that he had severe depression with psychotic symptoms. At this stage Mr. Z was prescribed antipsychotic medication, Olanzapine 5mg daily, with a view to raising it to 10mg daily after a seven-day interval.[63]

Diagnostic Decision Processes

Psychotic Depression

When interviewed medical witnesses told the Independent Investigation Team that Mr. Z presented in a calm and withdrawn manner, and that he was not at all agitated or *"worked up".* The medical team were not certain what was wrong with him, although they recognised he was not well. The initial plan was to observe him and formulate an assessment prior to treatment. Medical witnesses stated at interview that:

- they had not read the Accident and Emergency assessment notes or the nursing notes, depending instead on a verbal handover, and were surprised at the detail of information the notes contained (these had been read by the doctors after the incident);
- they believed Mr. Z's English to be limited;
- they had no understanding of Mr. Z's cultural diversity issues or of those of asylum seekers in general;
- it was not common practice to conduct a Mental State Examination in the ward round;

61 Medical Records PP 14-15
62 Medical Records P15
63 Medical Records PP 16-17

- Mr. Z needed to be assessed in the context of what was *"usual for people coming from Leopold Court"* (i.e. homeless people resident in Rochdale).[64]

Whilst the diagnosis of psychotic depression may not have been an unreasonable diagnosis to have reached on the 9 August 2007, Mental State Examinations were neither formulated nor recorded. At no point were Mr. Z's hallucinations, delusional beliefs or paranoid ideas explored with him, neither were Mr. Z's suicidal thoughts and feelings of distress and despair discussed with him. It would appear that the original diagnosis offered by the On Call Psychiatrist at Accident and Emergency on the 1 August 2007 was neither proved nor disproved by any kind of hypothesis developed by the medical team, and neither was Mr. Z assessed within the context of his personal history and cultural background.

Medical input into Mr. Z's assessment appears to have been minimal. The Hamilton Depression Rating Scale, the BPRS and the STAR risk assessments were all conducted by the Named Nurse. It must be stated here that the use of the Hamilton Rating Scale on a person whose first language was not English and was not from a Western culture rendered it (psychometrically) unreliable and as such an unsafe basis for arriving at conclusions about the type or severity of Mr Z's problems.

Post Traumatic Stress Disorder

It must be stated that not every person who experiences traumatic events goes on to develop PTSD. That Mr. Z was suffering from PTSD has not been assumed by the Independent Investigation Team. However PTSD is mentioned in his clinical record, and his background and symptomology require that the Independent Investigation Team assess how well this aspect of Mr. Z's care and treatment was managed. This is important as it represents a significant area of learning for the Trust which is increasingly having to treat a population that consists of a high number of asylum seekers.

Whilst it may never now be known whether or not Mr. Z was suffering from PTSD, it is a fact that PTSD was mentioned within his clinical record on the day of his admission to Hollingworth Ward. Therefore it would be reasonable to have expected this initial diagnosis either to have been confirmed or ruled out as quickly as possible.

64 Witness Transcriptions

The Independent Investigation Team could find no evidence to suggest that the notion of Mr. Z having PTSD was ever discussed by the medical team or that Mr. Z's presentation in this regard was assessed against national diagnostic guidance. One medical witness to the Independent Investigation did recall the possibility of some *"post traumatic issue"* being considered but had concluded that as the events in Ethiopia had taken place so long ago they could not have been a factor in the deterioration in his mental health as too long an interval had transpired.[65] This conclusion was not entirely correct.[66] While the ICD-10 diagnostic criteria for PTSD do anticipate an onset of symptomatology within six months of a traumatic event for a diagnosis of PTSD the schema does allow for a delayed onset of PTSD. The description of the diagnostic criteria begins as follows:

*"This disorder should not **generally** be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A **'probable' diagnosis** might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible."*

Similarly the NICE guidance on PTSD identifies that while the early onset of symptoms after a traumatic event is the most usual course for PTSD, it is not the only one.

"*The onset of symptoms is usually in the first month after the traumatic event, but in a minority (less than 15%; McNally, 2003) there may be a delay of months or years before symptoms start to appear."*

This 'typical' pattern of the onset of symptoms refers to the emergence of the PTSD symptomatology in a normal population. While the delayed onset of PTSD symptomatology may be relatively unusual in the general population it is not uncommon in refugee and asylum seeker populations, and is increasingly being identified in veterans of armed conflict.

"People may present for help many years after becoming refugees, in the same way as those who have been through a traumatic experience. Miller (1999) cites McSharry and Kinney's findings that in a randomised community sample of Cambodian refugees living in the USA,

65 Witness Transcription
[66] Witness Transcription

43% were suffering from post-traumatic stress disorder (PTSD) 12–14 years after resettling in the USA". (Tribe 2002)

The delay in the onset of symptomatology on its own should not have persuaded the clinical team to ignore the possibility that Mr. Z's mental health problems were a consequence of the traumatic events he experienced: being held in prison, being the victim of torture and the experiences of being an asylum seeker. An alternative ICD-10 diagnosis, which also identifies trauma as part of its aetiology, which might have been considered by the clinical team is 'enduring personality changes after catastrophic experiences.' (F62.0).

"The ICD-10 distinguishes between PTSD and 'enduring personality changes after catastrophic experiences.' (F62.0) The latter diagnosis arose from clinical descriptions of concentration camp survivors and is characterised by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or helplessness, a chronic feeling of 'being on the edge' as if constantly feeling threatened, and estrangement. 'Enduring personality change after catastrophic experience' can be an outcome of chronic PTSD, especially after torture or being held for a long period as a hostage."[67]

This diagnosis, like the diagnosis of PTSD, assumes that the sufferer has experienced a traumatic event, but it does not assume an onset of symptomatology within six months. The diagnosis of 'enduring personality changes after catastrophic experiences' shares much of its symptomatology with PTSD.

The NICE Guidelines comment:

"When a patient presents with PTSD and depression, healthcare professionals should consider treating the PTSD first, as the depression will often improve with successful treatment of the PTSD. However, in patients with a long history of PTSD or patients who have experienced multiple traumatic events and losses, the depression can become so severe that it needs immediate attention (i.e. it is a suicide risk), and dominates the clinical picture to the extent that it makes some forms of PTSD treatment impossible… Extremely severe depression would need to be treated before patients could benefit from such trauma-focused

[67] NICE Guidelines (2005): *The management of PTSD in adults and children in primary and secondary care*. CG26

treatments…For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals should first concentrate on management of this risk."[68]

Mr. Z presented with many of the NICE Guidance symptoms for PTSD:

- re-experiencing – flashbacks, nightmares;
- avoidance- avoiding people, situations or circumstances associated with the event;
- hyperarousal-hypervigilence for threat, sleep problems and irritability;
- emotional numbing-lack of ability to experience feeling;
- depression.

Mr. Z could also be seen as displaying many of the symptoms of enduring personality changes after catastrophic experiences:

- a definite and persistent change in the individual's pattern of perceiving, relating to and thinking about the environment and the self following exposure to extreme stress;
- a hostile and distrustful attitude towards the world;
- social withdrawal;
- a constant feeling of emptiness or hopelessness;
- an enduring feeling of being on edge or being threatened without external cause;
- a permanent feeling of being changed or different from others;
- personality changes which cause significant interference with personal and social functioning.

Whilst these symptoms on their own may not have positively ruled in PTSD or enduring personality changes, Mr. Z's reported history should have served to have alerted clinicians that a specialist assessment was indicated. The object of the diagnostic exercise is not to allocate labels but to bring together a set of symptoms allowing the clinician to understand an individual's difficulties better and so intervene more effectively. PTSD, especially when present with a psychotic disorder or depression can lead to violent, spontaneous acts, either in the form of harm to oneself or harm to others. Mr. Z instigated a violent, spontaneous act that led to the death of Ms. X.

68 NICE Guidelines 2005 Post-traumatic stress disorder : The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26 P13

12.1.2.3. Conclusions

It is not the task of an Independent Investigation Team to assign a diagnosis with the benefit of hindsight to a service user such as Mr. Z, or to strongly disagree with the diagnosis reached by the original clinical team. It is however the task of an Independent Investigation Team to conclude whether or not everything that was known about Mr. Z was taken into full account and acted upon appropriately.

It was evident from examining the case of Mr. Z that a significant amount of information was known about him at the point of his admission onto the ward. It does not appear that this information was read in a timely manner. His presentation and history was unusual and should have prompted an assertive response from the medical team.

The medical team decided to observe Mr. Z for a 48 hour period prior to commencing a treatment plan so that a diagnosis could be formulated. Whilst this can be seen as good practice, this kind of decision does depend upon a period of active assessment taking place as part of a planned strategy. Five days transpired between this decision being made and any action taking place. In the end Mr. Z was in hospital for a total of eight days before a diagnosis was agreed, it was then decided that the initial diagnosis of psychotic depression given in the Accident and Emergency department was correct. The Independent Investigation Team does not have an issue with this diagnosis, however it does find cause for concern in that:

- significant clinical information was not read or taken into consideration prior to this diagnosis being reached;
- minimal contact was made with Mr. Z by the medical team prior to this diagnosis being made;
- no Mental State Examination was undertaken or recorded;
- no consideration was given to the possibility of Mr. Z having PTSD;
- no consideration was given to Mr. Z's ethnic and cultural background and difficult personal history when formulating a diagnosis;
- rating scales inappropriate to his cultural background were used when trying to assess him;
- no explicit assessment plan was put in place while medical treatment was withheld.

As has been mentioned above, it cannot now be known whether Mr. Z had PTSD or enduring personality changes, it is however possible that this condition co-existed alongside that of a psychotic illness and severe depression. Mr. Z should have been appropriately assessed because people with PTSD present with a greater risk of harm to both themselves and to others.

"Many symptoms of PTSD can lead to… sudden outbursts of violence. Individuals with PTSD are often plagued by memories of the trauma and are chronically anxious. Feeling the need to be always 'on guard' can cause people to misinterpret benign situations as threatening and cause them to respond with self-protective behaviour. Increased baseline physiological arousal results in violent behaviour that is out of proportion to the perceived threat. It is common for trauma survivors to feel guilt, which can sometimes lead them to commit crimes that will likely result in their apprehension, punishment, serious injury, or death".[69]

Whilst a proven direct link cannot be made between a possible undiagnosed condition and the death of Ms. X, there is significant learning here for the Trust.

1. Clinicians should formulate and document the assessment process that leads to a diagnosis being made. Clear diagnostic criteria should be used.
2. Clinicians should read all of the information available to them prior to making a diagnosis.
3. Presumptive diagnoses at the point of referral e.g. PTSD need to be either ruled in or ruled out, not ignored.
4. Clinicians need to make diagnostic judgements in the context of a person's cultural background and personal history.
5. Once a diagnosis has been made then a multidisciplinary risk assessment and care and treatment plan should be formulated.
6. Clinicians should be up to date and aware of the significance and symptomology of PTSD, especially if it is potentially present with other co morbidities.

Whilst a definite link cannot be made between Mr. Z, PTSD and the death of Ms. X the Independent Investigation Team conclude that the Hollingworth Clinical Team should have pursued the initial concerns entered into the clinical record on the 1 August 2007 and

69 PTSD and Criminal Behaviour: A National Centre for PTSD Fact Sheet . Claudia Baker, MSW, MPH and Cessie Alfonso, LCSW

assessed him accordingly. By not doing so the clinical team has left itself open to the speculation that the *"calm and polite"* Mr. Z killed Ms. X whilst acting upon psychotic delusions potentially exacerbated by unidentified post trauma issues.

Following the death of Ms. X Mr. Z was diagnosed as having Paranoid Schizophrenia at the time of his pre-trial psychiatric report, it is not clear whether or not PTSD was also considered.

- ***Contributory Factor Number 2 (Influencing). The failure to assess Mr. Z within the context of his personal history and presenting symptomology led to a delay in providing him with an appropriate care and treatment plan. Delayed and inappropriate assessment also ensured that his condition was not considered in the full light of everything that was known about him at the point of his admission to the ward.***

12.1.3. Medication and Treatment

12.1.3.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, psycho education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as '*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Appointed Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

12.1.3.2. Findings

On admission to Hollingworth Ward it was decided to observe Mr. Z over a 48 hour period prior to any medication being prescribed in order to assess him 'drug free'. At the ward round on the 2 August 2007 the plan was for the GP to be contacted in order to ascertain whether or not Mr. Z was currently on any kind of medication. Mr. Z had arrived at Rochdale Infirmary the day before with a few remaining Trazodone capsules in his possession which had been prescribed by his previous GP in Blackburn. Unfortunately when the clinical team asked his new Rochdale GP what medication Mr. Z was currently being prescribed he only knew about the Ibrobrufen he had been prescribed recently for a bad back. This was because Mr. Z's GP notes from Blackburn were still in the process of being sent.

At the point of admission Mr. Z had been assessed as being:

- anxious and distressed;
- depressed;
- deluded;
- tearful;
- paranoid and experiencing nightmares and flashbacks regarding his torture;
- not sleeping;
- suicidal and threatening self harm;
- making threats to kill others;
- potentially expressing a psychotic depression and/or PTSD.

Medication

On the 6 August 2007 Mr. Z was seen by the ward Specialist Registrar. His presentation had not changed from the time of his admission on the 1 August six days previously. Following this review Mr. Z was commenced on Citalopram 20mg once daily, presumably to treat his depression, although this diagnosis was not recorded in the medical records.[70]

On the 9 August 2007 at the ward round Mr. Z was diagnosed as having severe depression with psychotic symptoms and was commenced on Olanzepine 5mg at night.[71]

70 Medical Records P15
71 Medical Records PP 16-17

During the early hours of the morning of the 13 August Mr. Z could not sleep, he was reported as being suspicious and too afraid to sleep in his bedroom for fear of people harming him. The On Call Doctor was consulted by the ward staff and Olanzepine 5mg prn was prescribed and given with little apparent effect.[72]

To summarise, for a six-day period following his admission Mr. Z received no medication. During this time his presentation remained the same. His distress was significant and his delusional thoughts and paranoid ideas remained unaltered. At no time was Mr. Z given medication to alleviate his significant distress, and it took nine days following his admission before an antipsychotic was prescribed to alleviate the delusions and paranoid ideas he had been reported as experiencing for at least two months previously.

Other Effective Evidence-Based Treatments

Nursing

On admission the Named Nurse conducted a STAR risk assessment and the following day, (2 August 2007) developed care plans. Four care plans were developed to address Mr. Z being:

1. *"low in mood, with fleeting suicidal thoughts";*[73]
   and as;
2. receiving his care and treatment as an informal patient in a locked facility*;*
3. having *"auditory hallucinations alongside delusional/paranoid ideas";*
4. having a sleep pattern described as *" poor and he is disturbed during the night by having nightmares/flashbacks of his torture in Ethiopia".*[74]

The required interventions were recorded as being:

- *"develop a patient-centred, therapeutic relationship;*
- *allow appropriate 1:1 time and space for Mr. Z to ventilate his thoughts and feelings;*
- *ensure Mr. Z is nursed on an appropriate level of observations;*
- *encourage Mr. Z to engage in ward activities to avoid social isolation and increase motivation;*
- *challenge Mr. Z's delusional/paranoid beliefs, offer reasonable explanations;*

72 Medical Records P.17
73 Nursing Records P 30
74 Nursing Records PP 30-35

- *discuss methods of distractions for Mr. Z to deal with his auditory hallucinations e.g. engaging with activities, listening to music;*
- *ask Mr. Z directly as to his suicidal ideation;*
- *begin a sleep chart to monitor Mr. Z's sleep pattern;*
- *encourage a good routine prior to going to bed; low stimulus environment, warm bath, warm milky drink;*
- *utilise prescribed medication to assist with sleep if necessary;*
- *liaise with the MDT".*[75]

There are two main issues that the Independent Investigation Team considered. First: the appropriateness of the nursing care plans and the identified interventions. Second: the efficiency and effectiveness of their delivery.

First: the care plans and interventions identified were appropriate based on the assumption that Mr. Z had a psychotic depression. However if Mr. Z had PTSD then the care plans and identified interventions could potentially have exacerbated his condition. It was evident that nursing staff were considering the notion that Mr. Z had PTSD as it was recorded in the nursing admission assessment documentation. It was evident that the Named Nurse did try to incorporate PTSD into the care plans, however it was also evident that she did not understand the nature of PTSD and the consequences of certain interventions being made.

People with PTSD find it difficult to talk about the traumatic experiences that have caused their mental ill health. Discussions about past trauma need to be conducted under highly controlled circumstances with practitioners who are expert in treating the condition. When this is not done it is common for a sudden deterioration in mental state to occur and for impulsive and destructive behaviours to ensue. This is because the 're-living' of past painful events can trigger distress levels of such a degree that the patient cannot control them.

The planned interventions of providing time to allow Mr. Z to ventilate his thoughts and feelings, whilst standard best practice for most mental health conditions, would need to be treated with caution when treating a person with a history and presentation such as Mr. Z had. From reading through the nursing patient progress notes it was evident that Mr. Z did discuss

75 Nursing Records PP 30-35

his thoughts and feelings on occasion regarding his torture and that his subsequent levels of distress were observed to rise. This was particularly in evidence on the morning of the 13 August 2007 when his disclosure of experiences of torture appear to have contributed to his heightened and continued levels of distress throughout the day. It would be unreasonable to speculate whether or not this contributed to the death of Ms. X later that same day. However it is a point of learning for the clinical team who provided care and treatment to Mr. Z that after disclosing details about his torture heightened levels of distress should have been expected and should have been proactively managed.

Second: most of the interventions identified in the care plans were appropriate. However the Independent Investigation Team, in common with the Internal Review Team, could find little evidence to suggest that these interventions were ever put into action. For example, the care plans sought to engage Mr. Z in ward activities in order to address his isolation. It would appear from examination of the clinical record that Mr. Z spent most of each day on his bed and little attempt was made to promote therapeutic activities and encourage him to take part in life on the ward. It is difficult to understand from examination of the clinical record what efforts were made to review Mr. Z's progress and the ongoing effectiveness of his care plans.

Multidisciplinary Inputs

During the time Mr. Z was a patient on the ward the Hollingworth clinical team was comprised of doctors and nurses only. Psychology and occupational therapy inputs were not a routine part of the staffing establishment. In the case of Mr. Z ward rounds and multidisciplinary meetings normally consisted of members of the medical team and the Named Nurse. Mr. Z was not able to access specialist psychology inputs during his stay on Hollingworth Ward, and neither was the clinical team able to access specialist advice on the kind of care and treatment plan that a person presenting with Mr. Z's history and symptomatology required.

12.1.3.3. Conclusion

The Independent Investigation Team concluded that Mr. Z did not receive the levels of care and treatment appropriate to either his history or presentation in a coherent and timely manner. It was evident that Mr. Z's presentation on admission did not alter during his time on the ward. He was depressed, distressed, deluded, hallucinated and paranoid. He was also unable to sleep much of the time, expressed suicidal ideation and talked about nightmares and

flashbacks. The medical team decided to assess Mr. Z drug free for a period of 48 hours following his admission. Whilst this can be seen as good practice, this kind of decision requires a coherent strategy for assessment. It remains unclear why Mr. Z was in fact left for a period of six days prior to any kind of medication being considered, and why no psychiatric assessment took place during this period.

On day six Citalopram 20mg was prescribed, however it was to be another three days before an antipsychotic was commenced. During this period Mr. Z experienced significant periods of distress. At no stage was any medication considered to help Mr. Z with his anxiety and insomnia which caused him significant anguish. However it is the view of the Independent Investigation Team that Citalopram and Olanzapine were prescribed appropriately, albeit not in a timely manner.

The other issue relating to Mr. Z's medication was as much a humanitarian one as a clinical one. He was clearly distressed and unable to sleep and lack of sleep is known to exacerbate anxiety and distress. Prescribing short-acting medication for this was unlikely to have affected the clinical picture that the team were intending to assess. Any first-line treatment for either psychosis or depression would have taken some time (10-14 days) to begin to have an effect and so again, to have a short acting/term intervention to address Mr. Z's distress would have been appropriate and humane.

We cannot know what effect a reduction in his escalating distress would have had on his mental state but it is more likely to have been beneficial than detrimental and would not in itself have removed either psychotic depression or PTSD symptomatology but might have allowed Mr Z to report this more cogently.

Nursing interventions were, on the whole, well considered and appropriate. However as has been pointed out above, certain planned interventions may have served to inadvertently exacerbate Mr. Z's anxiety and distress. It would also appear that the identified care plan interventions were not, in practice, implemented.

It was evident from examining the clinical record and from interviewing the clinical witnesses that Mr. Z's presentation and personal history placed his situation outside of the experience and skill set of the clinical team who provided care and treatment to him. It is

possible that had the clinical team had access to a wider multidisciplinary skill set Mr. Z's condition could have been assessed and managed more effectively. As it was Mr. Z received a medication regimen that did not address his short-term anxiety issues and neither did he receive an in-depth assessment that led to a coherent plan to care, treat and manage his clinical condition. It is unclear what would have been offered to Mr. Z had the death of Ms. X not occurred. However it is a fact that during Mr. Z's 13-day stay on Hollingworth Ward he did not receive:

- a comprehensive psychiatric assessment based on what was known, and should have been known about him;
- a culturally appropriate set of assessments that took into account his personal history and presentation;
- a comprehensive evidence-based care and treatment plan.

During the 13 days that Mr. Z was on Hollingworth Ward no comprehensive care and treatment plan was formulated that was based upon a sound multidisciplinary assessment. It would appear that due to the fact Mr. Z presented as a polite and quiet man, who presented no distinct management problems on the ward, he was in effect left to his own devices most of the time. Whilst a regimen of time, a safe environment, and medication alone can often effect a dramatic improvement in the mental health of some patients, with others it cannot. In the case of Mr. Z his condition and symptomology appeared to gradually escalate and by the 13 August 2007 he was highly distressed and confused. At this stage both the ward medical and nursing staff recorded that he was distressed, unhappy and paranoid, but this did not lead to a reassessment or reformulation of his care and treatment plan. By this stage, in Mr. Z's own words, he *"didn't know what the problem was. So finally I decided that the final solution is to kill myself…cos rather than suffering this kind of situation I thought that it is better to kill myself."*[76]

We know that Mr. Z did not kill himself as he was unable to find the means to do so. Instead we know that Mr. Z killed Ms. X when he was in a highly charged and distressed state of mind.

76 Home office and Police Documentation File P.P.262-263

- ***Contributory Factor Number 3 (Influencing). The care and treatment plan offered to Mr. Z was not based upon a comprehensive or coherent assessment process. Consequently it was not possible to understand exactly what problems the clinical team were hoping to affect. The clinical team did not have a clear formulation of Mr. Z's problems and did not identify any clear goals for treatment. One may not expect depressive or psychotic symptoms to be abated in 13 days. However Mr. Z's anxiety, fear, agitation, restlessness, poor sleep and overall distress could have been managed more effectively.***

12.1.4. Use of the Mental Health Act (83)

12.1.4.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[77]

Section 131 of the Mental Health Act (83 and 07) allows for people to be admitted into a psychiatric hospital on either a voluntary or informal basis, this means they can be treated without a compulsory detention order. Following the Bournewood findings in 2004 at the European Court of Human Rights a distinction was made between 'voluntary' and 'informal'.

77 Mental Health Act Commission 12th Biennial Report 2005-2007

'Voluntary' patients are people who are judged to have full capacity to consent or refuse consent to treatment; this means that they have the right to refuse all treatment and to discharge themselves from hospital at any time they wish. An 'informal' patient is a person who is judged as not having the capacity to give consent. This means that whilst they may raise no objection to being admitted and receiving treatment additional measures have to be taken to ensure their continued risk is contained and that their human rights are safeguarded. Many mental health Trusts in effect treat 'voluntary' and 'informal' patients in the same way. It is not clear whether Mr. Z was judged as having capacity or not during his admission on Hollingworth Ward.

12.1.4.2. Findings

On the 1 August 2007 it was decided that Mr. Z required admission to an acute inpatient psychiatric facility. Mr. Z raised no objections to being admitted into hospital and it was decided to admit him as an informal patient.

Hollingworth Ward is a locked facility and the nursing clinical documentation recorded that Mr. Z was advised of this fact and that he gave his consent to receive his care and treatment in such an environment insofar that an automatically generated care plan was placed in his notes. This care plan stated that Mr. Z had been informed of his rights and that on admission his capacity had been assessed. The care plan also stated that:

- if the patient (in this case Mr. Z) did not sign the care plan indicating that this matter had been discussed and agreed, then a full written explanation would be placed within the clinical record;
- the patient could withdraw their consent at any time with regard to receiving their care and treatment in such an environment, and that should this occur, then nursing staff would organise a review by the ward doctor prior to allowing a patient to leave the ward;
- the care plan would be reviewed daily and the outcome would be documented in the nursing notes;
- the situation would be reviewed each week at the multidisciplinary team meeting.

Mr. Z did not sign the care plan. No written explanation was given as to why this was the case, and no daily review or multidisciplinary team weekly review was recorded. It is unclear how much information Mr. Z was given at the point of his admission.

The care plan generated on the 1 August 2007 stated that had Mr. Z tried to leave the ward he would have been somehow 'detained' until such time as a doctor could have been called to review him. This would indicate that Mr. Z was being held as an informal patient under the Bournewood definition. However it is unclear from the clinical record why Mr. Z had been assessed as being 'informal' as opposed to being 'voluntary' under the Mental Health Act (83). There was no recorded evidence to suggest that an assessment with regard to his capacity was conducted by either a doctor or the Named Nurse at the point of his admission.

It would appear that the care plan placed in Mr. Z's clinical records was a standard plan that was automatically generated for every informal patient on Hollingworth Ward. As is sometimes the case with automatically generated care plans it would appear that 'lip service' only was given to it. The care plan gave clear guidance:

- on admission each informal patient was to have their capacity assessed by the ward consultant or deputy in conjunction with the admitting nurse;
- all informal patients were required to have their rights explained to them with regards to receiving their care and treatment on a locked ward;
- consent to receiving care and treatment on a locked ward was to be given by each patient and the care plan signed as a formal recognition that this consent had been given;
- each patient should be reviewed daily by the nursing staff and weekly by the multidisciplinary team.

It would appear that these actions did not take place as no record of such activity exists in Mr. Z's clinical documentation.

12. 1.4.3. Conclusions

There are two issues that the Independent Investigation Team wishes to draw to the attention of the Trust. These issues do not have any direct bearing upon the death of Ms. X, but form key learning points. They are:

1. Trust policy and procedure were not followed;
2. Trust policy and procedure did not appear to distinguish between 'voluntary' and 'informal' patients.

First: it was evident from examining the clinical record that the basic requirements set out clearly in the automatically generated care plan were not followed. At no time would it appear that Mr. Z's capacity was formally assessed and recorded.

Second: it was evident that the Trust care plan and admission process did not distinguish between patients being admitted in a voluntary capacity as opposed to an informal capacity. It is never good practice to admit patients not requiring detention under the Mental Health Act under a general banner of 'informal'. The key deciding factor between a voluntary patient and an informal one is that of capacity. The Trust policy in place in 2007 would in effect, illegally prevent a voluntary patient from leaving the ward, as they would not require a medical opinion prior to taking their own discharge.

During the 13 days that Mr. Z received his care and treatment on Hollingworth Ward he made no attempt to leave or to seek his own discharge. It was unclear what the clinical response would have been had he decided to do so. No assessment was made with regard to his capacity, and no regular review took place. Whilst this had no direct impact upon the care and treatment that Mr. Z received the Trust should ensure that there is no ambiguity regarding the care and treatment of voluntary and informal patients.

- ***Service Issue Number 1. The Trust did not distinguish between the rights of informal and voluntary patients. Admission processes were not clear and would serve to potentially mislead both clinicians and patients alike.***

12.1.5. The Care Programme Approach

12.1.5.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[78]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to

78 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990

incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach*[79].

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services*[80]." (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and
  - to take immediate action if it is not

79 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008

80 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

Pennine Care NHS Foundation Trust CPA Policy

The policy extant at the time Mr. Z was receiving his care and treatment on Hollingworth Ward stated that the main aims of the Care Programme Approach were to provide:

- *"consistent standards of assessment for all those accepted by the mental health service and their carers;*
- *coordinated and systematic care planning for all those with severe mental health problems and their carers;*
- *the identification of effective support to high risk service users;*
- *ensuring service user involvement as a continuous process during the provision of care;*
- *identifying unmet need."*[81]

The policy also stated that:

*"**All** service users admitted to hospital, irrespective of age or condition, will have their care managed in accordance with the Trust Hospital and Admission Policy",* and that *"CPA applies to all those accepted by specialist mental health services irrespective of setting. All service users requiring care and treatment in hospital should have their admission and discharge managed in accordance with the procedures outlined in this policy".*[82]

The policy criteria for Enhanced CPA were:

- *"multiple care needs e.g. housing, employment, finances;*
- *require contact with, and cooperation between, a number of agencies or professionals but may be willing to cooperate with only one;*
- *be at risk of losing contact with services;*

81 Trust CPA Policy Version 3
82 Trust CPA Policy Version 3

- *pose a significant risk to themselves or to others or have a history of serious self harm or violence;*
- *lack an informal support network;*
- *have substance misuse difficulties in addition to their mental health problem(s)".*[83]

At the time Mr. Z was receiving his care and treatment he would have met the criteria for Enhanced CPA.

12.1.5.2. Findings

During his time on Hollingworth Ward Mr. Z's Named Nurse referred him to the Community Mental Health Team (CMHT). It was not evident from reading the copies of the referral documentation when exactly this occurred. The referral form stated clearly that patients should only be referred to the CMHT if they required care coordination for an Enhanced level of CPA and met the following criteria:

- *"suffer substantial disability as a result of their illness, such as an inability to care for themselves independently, or the inability to sustain relationships;*
- *are currently displaying florid symptoms (maybe first episode) or suffering from a chronic, enduring condition;*
- *have suffered recurring crisis leading to crisis admissions and/or intensive interventions and is being considered for Enhanced CPA."*[84]

The referral documentation required the following information to be set out:

- reason for admission;
- medication;
- expectations of CMHT;
- intervention required.

The referral information supplied was not particularly helpful, it simply said:
"Staff at Leopold Court became concerned as Mr. Z became isolative and paranoid - believes others are talking about him and that he is a spy, and that his food is poisoned. Also has been having flashbacks re-torture in Ethiopia. Citalopram 20mg OD, Olanzepine 5mg nocte."

83 Trust CPA Policy version 3
84 Nursing Records P 10

It was evident from reading Mr. Z's clinical records that his assessment whilst on the ward was not of a holistic nature that lent itself to the Trust CPA ethos. The Trust CPA policy expected that an initial health and social care needs assessment should be initiated at the first face-to-face contact with mental health services. This initial CPA assessment should consider the following areas:

- *"mental health (symptoms; psychology and emotional features);*
- *physical health;*
- *social functioning;*
- *personal/family circumstances;*
- *child care/protection issues;*
- *employment, vocational and leisure needs;*
- *finances/welfare benefits;*
- *accommodation;*
- *medication and medical history;*
- *religious and spiritual needs;*
- *communication and cultural needs;*
- *advocacy needs;*
- *risk."*[85]

The policy also stated that the CPA documentation should be recorded using locally agreed documentation. No specific Trust-wide documentation was advocated.

The Hollingworth Ward assessment conducted for Mr. Z and the documentation that it was recorded upon provided for a traditional 'medical model' assessment process. Mr. Z's mental health, physical health, risk and medication needs were assessed. However these needs were assessed in isolation. No attempt was made to assess Mr. Z within the context of his social care and cultural needs which were extensive and highly significant.

12.1.5.3. Conclusions

There are three specific issues that need to be highlighted with regard to CPA and the care and treatment that Mr. Z received on Hollingworth Ward.

85 Trust CPA Policy-version 3 P.13

First: it was evident from examining Mr. Z's clinical records that the ward was not working within a culture that embraced the ethos of CPA. According to the extant Trust CPA policy in operation at the time Mr. Z should have expected the CPA process to have commenced at the time of his first face-to-face meeting with secondary care services. Whilst Mr. Z's psychiatric condition was considered there was no attempt made to assess him in the light of social care and cultural needs.

Second: the Trust CPA policy allowed for assessments to take place on locally agreed documentation. The documentation available on the ward at the time of Mr. Z's admission did not lend itself well to the implementation of CPA. The 'Admission and Initial Assessment Details' form used on the ward did not require any social functioning, cultural, religious/spiritual, accommodation, welfare, or employment information to be collected. Neither did it lend itself to a comprehensive and holistic assessment of need being made. As has been mentioned above, Hollingworth Ward did not function with a multidisciplinary team. This may explain why such a 'traditional' medical model approach was taken to the assessment and identification of need. Whatever the reason, it contributed to Mr. Z not receiving an appropriate level of intervention and support.

Third: the referral made to the CMHT did not contain sufficient information to facilitate a timely and appropriate response for the allocation of a care coordinator to Mr. Z. The information made available was of a basic nature only, and had the incident not taken place, may have led to a substantial delay in Mr. Z being care coordinated and discharged and supported appropriately.

The Care Programme Approach should never be seen as a tokenistic 'tick box' process. When undertaken properly it provides for a comprehensive holistic assessment that assists in both understanding the patient and in planning the care and treatment interventions that need to be made available. Had Mr. Z received a full CPA assessment at the inception of his care and treatment then it is probable that he would have been managed differently. Mr. Z was in a highly distressed state for much of the time that he was on Hollingworth Ward. He was never understood in the full context of his personal history and cultural background. Neither were his considerable social care needs explored. Mr. Z received a fairly basic clinical assessment of his psychiatric condition; this did not go far enough to understand the needs of this complex individual.

- ***Contributory Factor Number 4 (Influencing). The failure to provide CPA to Mr. Z meant that he did not receive a comprehensive and holistic assessment. This in turn ensured that he was never understood fully in the context of his personal history, social care needs and cultural background. This contributed to the failure to provide Mr. Z with the interventions and support that he needed.***

12.1.6. Risk Assessment

12.1.6.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that '*positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed'*[86].

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Pennine Care NHS Foundation Trust Policy

The Trust Clinical Risk Assessment and Management Policy (version one) that was in place at the time of Mr. Z's admission to Hollingworth Ward made a direct reference to the extant Care Programme Approach Policy and stated that the assessment of risk was an integral part of CPA. It was stated in the policy that of particular note was:

- *"the assessment of risk;*
- *the documentation of risk;*
- *the communication of risk;*
- *the adoption of appropriate risk management strategies based on the assessment".*[87]

86 Best Practice in Managing Risk; DoH; 2007

87 Trust Clinical Risk Assessment and Management Policy Version 1 P6

Roles and responsibilities were not explicitly defined as being multidisciplinary. However the policy did state that *"it is the responsibility of Care Coordinators, primary nurses, key workers and assessment officers, to ensure that they undertake and/or contribute to formal risk assessment for service users, and to ensure that they have undertaken the approved training in order to do so."* [88]

12.1.6.2. Findings

Events History

At the point of Mr. Z's admission on the 1 August 2007 his Named Nurse commenced a risk assessment by utilising the STAR initial risk assessment screen. The following day the Named Nurse completed the risk assessment process. These actions were in accordance with the Trust policy that required *"risk assessment will be incorporated into the initial screening and assessment of the service user".*[89] There is no evidence to support the view that any further risk assessment was undertaken during Mr. Z's time on Hollingworth Ward and no risk assessment formulation appears in the medical notes to indicate that the medical team considered Mr. Z's risk profile as part of his ongoing mental state assessment.

Risk Assessments and Management Plans - Process and Procedure

On the 1 August 2007 the STAR Initial Risk Assessment Screen indicated the following:

Self harm/Suicide

Self Harm/Suicide	**Yes**	**No**	**Don't Know**
Current behaviour suggesting there is a risk of self harm/suicide		X	
Recent bereavement or anniversary of		X	
Past history of self harm/attempted self harm		X	
Thoughts or plans which indicate there is a risk of self harm or suicide	X		
Mental illness (e.g. depression, psychotic illness) personality disorder			X
Current problems with alcohol or substance abuse		X	
Any expression of concern (especially form a relative or carer about the risk of self harm/suicide	X		
Was serious intent expressed relating to any act of self harm/attempted suicide		X	
Any attempt to conceal an act of self harm		X	
Currently experiencing/responding to command hallucinations			X
Is full risk assessment of this domain indicated?	**X**		

88 Trust Clinical Risk Assessment and Management Policy Version 1 P 5
89 Trust Clinical Risk Assessment and Management Policy Version 1 P. 7

Violence

Violence	**Yes**	**No**	**Don't Know**
Current thoughts/plans or symptoms indicating a risk of violence or harm to others		X	
Current behaviour suggesting there is a risk of violence or harm to others		X	
Current problems with alcohol or substance abuse		X	
Any expression of concern from others about the risk of violence		X	
History of sexually inappropriate behaviour			X
Physical factors e.g. acute confusional state		X	
Evidence of disinhibited behaviour		X	
Any risk toward children (intentional or unintentional)		X	
Evidence or arson or fire setting		X	
Current risk of violence from others		X	
Forensic history			X
Index offences			X
Currently experiencing/responding to command hallucinations			X
Is full risk assessment of this domain indicated?		**X**	

Serious Self Neglect

Serious Self Neglect	**Yes**	**No**	**Don't Know**
Fluid/dietary problems		X	
Personal hygiene problems		X	
Risk of accidents (to self or others)		X	
Untreated physical illness		X	
Non-compliant with medication		X	
Relapse risk			X
Non-compliance with treatment for physical illness		X	
Alcohol/substance misuse		X	
Homelessness	X		
Is full risk assessment of this domain indicated?		X	

Exploitation/Vulnerability

Exploitation/Vulnerability	**Yes**	**No**	**Don't Know**
Exploitation		X	
Disinhibited behaviour		X	
Grandiose ideas		X	
Confusion/disorientation, forgetfulness, diagnosed dementia		X	
Concerns regarding home condition, environment		X	
Physical health		X	
Risk of falls		X	
Wandering		X	
Night disturbance	X		

Is a full risk assessment of this domain indicated?		X	

The Named Nurse completed the STAR initial risk assessment in a timely and appropriate manner based on what was known to her at the time. The Named Nurse indicated that the self harm/suicide domain would require a full risk assessment to be completed. This was done the following day, the results of which are set out below:

Self Harm/Suicide

Self Harm/Suicide	**Yes**	**No**	**Don't Know**
Low in mood	X		
Current suicidal ideation	X		
Current misuse of drugs/alcohol		X	
Impulsivity		X	
Hopelessness	X		
Recent disengagement or non-compliance		X	
High level of distress		X	
Physical illness or disability		X	
Lives alone (will do after discharge)		X	
Social isolation	X		
Recent discharge from hospital. 1st home leave after self-harm attempt		X	
Concern expressed by significant others	X		
Past history of self harm		X	
Family history of self harm			X

In addition the Named Nurse wrote: *"Mr. Z had made no recent attempts to self harm and states he has no history. Recently feeling low in mood, hearing derogatory voices. Having nightmares about torture in Ethiopia. This morning had thoughts of hanging himself but no plans".*[90] No specific risk management plans were developed however a care plan was written in relation to Mr. Z's suicidal thoughts. The documented risk assessment process would appear to have 'made a good start,' however the problem was that it was not revisited during the remainder of Mr. Z's stay on the ward.

Once Mr. Z's risk assessment was completed on the 2 August 2007 no further attempts were made to revisit it and update it in the light of new information. Mr. Z's diagnosis, personal history and cultural background did not appear to influence any aspect of Mr. Z's risk assessment or subsequent identification of need or risk management plan. At no stage was a

90 Nursing Records P22

multidisciplinary discussion regarding risk assessment recorded and the Named Nurse's input appears to be have been the sole contribution that was made.

It remained unclear to the Independent Investigation Team how much supervision the Named Nurse received whilst going about her duties on the ward. At the time of the incident the Named Nurse was a Staff Nurse who had been qualified for one year, she was therefore a relatively junior member of the clinical team. This Investigation is not criticising the practice of this individual but found that the clinical team did not have a culture of multidisciplinary risk assessment in place at the time of the incident which in effect 'rested' Mr. Z's case upon the shoulders of the Named Nurse who did not have a broad understanding of the diagnostic and cultural complexities of Mr. Z's case. At interview medical witnesses told the Independent Investigation Team that compiling risk assessments on the Trust documentation was not a medical task and that this task was usually completed by nurses who would then share anything of relevance with the doctors at the ward round. The Independent Investigation Team realise that this was the view of a single medical team, and that it does not necessarily represent the view of the Trust. However in the case of Mr. Z the lack of *any* medical input into the assessment of Mr. Z's risk, either on the STAR documentation or as the narrative part of a Mental State Examination, would appear to have made a significant contribution to the poor clinical management of this particular case.

12.1.6.3. Conclusions

The initial risk assessment appears to have been appropriately conducted based on what was known to the Named Nurse at the time. However it was evident that a great deal of information about Mr. Z was collected over the 13 days that he was a patient on Hollingworth Ward. Had this information been collated on a regular basis, and had risk assessment continued in a dynamic and multidisciplinary manner, then a very different picture relating to the levels of risk Mr. Z presented would have emerged and this should have led to a more proactive management stance of his care and treatment being taken.

Another important factor was that Mr. Z was not risk assessed in the light of his presenting symptomology or personal history. The notion of PTSD coexisting with a psychotic depression was not considered. The possible presence of PTSD was recorded on the day of Mr. Z's admission. This should have raised particular concerns regarding the potential risk that he presented both to himself and to other people. In effect this was completely ignored.

The risk assessment process deployed for Mr. Z was not comprehensive, dynamic, or multidisciplinary. It would appear that in Mr. Z's case risk assessment was in part a paper exercise that did not lead to the careful consideration of how his risk was to be identified, managed and understood.

The Independent Investigation Team understood that Mr. Z was considered to be quiet and polite whilst on the ward and that he was not violent or aggressive during this time. It would appear that the main concern was the risk of self harm or suicide, this was not unreasonable. However Mr. Z was recorded as stating prior to his admission that he would have to either kill himself or *"them".* It was evident that he was deluded and distressed during his time on the ward. This should have prompted a Mental State Examination in order to understand what was going on in Mr. Z's mind and why he was voicing these thoughts. The fact that this was not done meant that no opportunity was taken to access Mr. Z's thinking, to understand him better, and thereby to assess the risk presented both to himself and to other people.

- ***Contributory Factor Number 5 (Influencing). Mr. Z was not assessed within the context of a comprehensive and dynamic risk assessment process. This ensured that Mr. Z was not understood within the context of his presenting symptomology and no appropriate management plan was either developed or implemented.***

12.1.7. Referral, Transfer and Discharge Planning

12.1.7.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

12.1.7.2. Findings

Transfer from the Rochdale Infirmary to Hollingworth Ward

Mr. Z arrived at the Rochdale Infirmary at midday on the 1 August 2007. He was transferred to Hollingworth Ward at 20.00 hours the same day. Whilst at the Rochdale Infirmary Mr. Z was assessed, and then referred to specialist secondary care mental health services in an appropriate manner. However it has to be noted that he spent at least seven hours in the Accident and Emergency Department which cannot be considered as being ideal for either the Accident and Emergency Department or for Mr. Z who was described as being in a state of *"marked distress".* [91]

Whilst it was uncertain when the Accident and Emergency clinical records arrived onto Hollingworth Ward, the doctor who had assessed Mr. Z came onto the ward and provided a verbal handover to the nursing staff.

Referral to the Rochdale Community Mental Health Team

Whilst Mr. Z was on Hollingworth Ward he was referred to the Community Mental Health Team (CMHT), presumably with a view to having him accepted onto the Rochdale CMHT caseload. It is not recorded in the documentation when this referral was made, or why it was made.

12.1.7.3. Conclusion

The Independent Investigation Team concludes that the referral and transfer process from the Rochdale Infirmary was managed well, notwithstanding the seven-hour interval that transpired between Mr. Z's initial presentation at Accident and Emergency and his eventual admission to Hollingworth Ward. Whilst the clinical records did not arrive on the ward with Mr. Z the assessing doctor visited the nursing team in order to provide a verbal face-to-face handover.

The referral to the Rochdale CMHT was appropriate, however on this occasion the information provided by the ward was of a poor quality and would not necessarily have facilitated a timely response.

91 Medical Records P 5

The Independent Investigation Team have no other observations to make under this subsection.

12.1.8. Cultural Diversity and the Care of Asylum Seekers

12.1.8.1. Context

Cultural Diversity

The terms of reference for this Investigation asked the Independent Investigation Team to assess *"the suitability of care and treatment in view of the service user's history and assessed health and social care needs."* In the case of Mr. Z his personal history and cultural background are central to understanding whether or not his care and treatment was suitably provided.

Black and Minority Ethnic (BME) individuals often appear to be subject to a paradoxical effect when accessing mental health services. The paradox is that many BME groups actively avoid mental health services and yet these same groups are represented by a significantly high presence within the mental health system. Research informs us that current mental health services within the United Kingdom have been based on a westernised model of psychiatry. It is a fact that some cultures accept the notion of mental illness more readily than others. These cultures will access mental health services and accept treatment programmes. Other cultures may be reluctant to consider the notion of mental illness with issues such as cultural stigmatisation, fear of the unknown and basic communication and language difficulties becoming barriers to accessing help.[92]

It was stated within the Department of Health's *Delivering Race Equality in Mental Health Care* (2005) action plan that healthcare organisations must challenge discrimination, promote equality and respect human rights, and that organisations must enable all members of the population to access services equally.[93] The Government's expectation for the future of mental health services is set out below.

92 http://www.rethink.org/about_mental_illness/who_does_it_affect/black_minority_ethnic_groups/index.html

93 Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*, (2005)

The vision for Delivering Race Equality is that by 2010 there will be a service characterised by:

- *less fear of mental health services among BME communities and service users;*
- *increased satisfaction with services;*
- *a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;*
- *a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;*
- *fewer violent incidents that are secondary to inadequate treatment of mental illness;*
- *a reduction in the use of seclusion in BME groups;*
- *the prevention of deaths in mental health services following physical intervention;*
- *more BME service users reaching self-reported states of recovery;*
- *a reduction in the ethnic disparities found in prison populations;*
- *a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;*
- *a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and*
- *a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.*

Disadvantage and discrimination characterise the experiences of many people from black and minority ethnic communities, especially in the area of health and health care. They experience poorer health, have reduced life expectancy and have greater problems accessing health services than the majority white British population. For mental health, major concerns include disparities and inequalities in terms of rates of mental ill health, service experience and health outcomes.

Standard One of the National Service Framework for Mental Health (Department of Health 1999) requires health and social services to:

- promote mental health for all, working with individuals and communities;

- combat discrimination against individuals and groups with mental health problems and promote their social inclusion.

The Needs of Asylum Seekers

It must be noted here that not all asylum seekers experience mental health problems. However when seeking asylum a person's life is turned upside down and if that person has also experienced bereavement, deprivation or torture in their country of origin then there may be significant adjustment issues to encounter once they have settled in the United Kingdom.

In 2004 the Department of Health identified the following issues that asylum seekers face when presenting for help from mental health services:

"Key mental health issues for refugees and asylum seekers

General:

- *Racism*
- *Stigma (often from within their own culture)*
- *Language barriers*
- *Cultural beliefs and practices*
- *Poor public perception*

Social risk factors:

- *Poverty*
- *Unemployment*
- *Loneliness and isolation*
- *Homelessness*
- *Displacement and lack of belonging*
- *Loss of identity*

Health:

- *High rates of anxiety and depression*
- *Experience of traumatic events impacts on mental health*

Service issues:

- *Lack of knowledge of services*
- *Problems accessing services*

- *Delay seeking help".*[94]

In 2003 the Home Office stated that: *"healthcare professionals are concerned that asylum seekers are being 'moved from place to place' by NASS and its accommodation providers. Welfare workers noted that their clients had reported being moved into and out of emergency accommodation with little warning, and had even been required to move from town to town on some occasions. This high mobility makes it difficult for asylum seekers to obtain registration with medical practitioners and healthcare programmes"* and that *"high mobility also means that healthcare providers are often required to treat asylum seekers in the absence of medical notes, which do not follow in time."*[95]

Differential Diagnosis: Asylum Seekers and PTSD

While PTSD is relatively common amongst the refugee and asylum seeker populations, perhaps in part as result of the experiences of being a refugee, clinicians must not make the unwarranted assumption that all refugees/asylum seekers suffer from PTSD or suffer only from this disorder. The NICE guidelines note:

" Differential diagnoses

Post-Traumatic Stress Disorder is not the only disorder that may be triggered by a traumatic event. Differential disorders (and indicators) to be considered are:

- *depression (predominance of low mood, lack of energy, loss of interest, suicidal ideation)*
- *specific phobias (fear and avoidance restricted to certain situations)*
- *adjustment disorders (less severe stressor, different pattern of symptoms; see below)*
- *enduring personality changes after catastrophic experience (prolonged extreme stressor)*
- *dissociative disorders*
- *neurological damage due to injuries sustained during the event*
- *psychosis (hallucinations, delusions).*

PTSD may also exist co morbidly with many of the above disorders, in particular depression and anxiety disorders". [96]

94 DH Celebrating our Cultures: Mental Health Promotion with Refugees and Asylum Seekers (2004)
95 Home Office. Asylum Seeker in Dispersal: Healthcare Issues. (2003)
96 NICE Guidelines 2005 Post-traumatic stress disorder : The management of PTSD in adults and children in primary and secondary care. National Clinical Practice Guideline Number 26 PP11-12

12.1.8.2. Findings

At no stage during the 13 day period that Mr. Z was a patient on Hollingworth Ward were his personal history, ethnicity or cultural background taken into account when considering his diagnosis, mental state, and health and social care needs. It is a fact that the documentation utilised by the ward when assessing Mr. Z did not have a designated space in which religion or spiritual beliefs could be recorded. Had the ward staff utilised appropriate CPA documentation then it is possible that Mr. Z would have received a more culturally appropriate assessment. As it was not even the most basic considerations were observed. At the time of writing this report the Independent Investigation Team remained unclear as to Mr Z's religious or spiritual beliefs as these had not been recorded in any clinical documentation presented to this Investigation by either by the Pennine Care NHS Foundation Trust or Ashworth Hospital.

Ethiopian Culture and General Cultural Diversity Issues

In Ethiopia, there are three main cultural influences: Traditional African, Coptic and Islamic. "*Irrespective of the religious affiliation, people share very much the same ideas on human nature and the world. Regarding mental disorders, but also many somatic disorders, the commonly shared belief is that they are caused by spirits or by other evil forces. Generally, there is no clear-cut division between physical and mental disorders and accordingly there is a clear interaction between physical and spiritual healing, for example when spiritual formulas have to be ingested or when herbal remedies have to be gathered with proper spiritual ceremonies. There are several different indigenous institutions for dealing with mentally disturbed people. In the Coptic Church, there are monks and priests that are specialized in healing practices often using holy water sites. In the traditional African context, there are different kinds of spiritual healers who are in direct contact with the spiritual world, from which they get information and directives for the treatment. In the Muslim culture, there are also spiritual leaders who are praying and preparing charms with writings on paper or skin of words of Allah, but who also practice healing with herbs and surgery."* [97]

Studies have found that in general Ethiopian people believe mental illness to carry a stigma with few differences in this belief found between socio-demographic groups. In 2001

97 Lars Jacobson Traditional treatment of mental and psychosomatic disorders in Ethiopia (2003)

research found that 27% of the population studied believed that supernatural forces caused mental illness and 65% of the population studied believed that prayer was the most effective method when dealing with mental health problems.[98] The Independent Investigation Team cannot speculate as to what Mr. Z believed with regard to mental illness in general or to his own experience in particular, however it would not be unreasonable to assume that the situation that he found himself in on Hollingworth Ward was entirely alien and unfamiliar to him. This alone could potentially have served to increase his anxiety and distress.

It is interesting to note how throughout his stay on Hollingworth Ward Mr. Z was described as being calm and polite. Entries in the nursing record describe him as appearing *"settled and pleasant"* whilst also describing him as *"tearful, facially low, and isolative"* do not specify that he was distressed or unduly anxious. Minnesota, in the United States of America, has the largest population of refugee Ethiopians in the world. Guidance given to health care professionals in Minnesota states that *"Ethiopians tend to speak softy and politely"* and that they are modest and will not draw attention to themselves, and that it is essential to get to know each person as an individual in order to ensure that their needs are understood fully.[99] The Independent Investigation Team acknowledges that to some extent it has been able to work with the benefit of hindsight, however this example serves to illustrate how a person from one culture can be completely misread by those from another.

Asylum Seeker Mental Health Issues

It was made evident to the Independent Investigation Team, when interviewing clinical witnesses, that no consideration was given to Mr. Z's asylum seeker background when assessing his mental state on the ward. Key assumptions were made about Mr. Z based on the fact that he had been referred by Leopold Court. The clinical team decided to assess and manage Mr. Z in the same way that they would normally for any person coming to them from a homeless person's hostel. Unfortunately Mr. Z had a more complex set of problems than this approach would have been able to address. It was inappropriate and stereotyped Mr. Z in an entirely unacceptable and unhelpful manner.

The mental health problems that asylum seekers routinely face have been set out above. Mr. Z presented with the following:

98 Shibre, Negash, Kullgren, Kebede, Alem, Fekadu, Methdin, Jacobson, Traditional treatment of mental and psychosomatic disorders in Ethiopia (2001)
99 http://www.culturecareconnection.org/matters/diversity/ethiopian.html

- depression (motor retardation, hopelessness, tearfulness);
- suicidal ideation;
- psychosis (delusions, paranoid ideas and hallucinations);
- phobias;
- fear (anxiety, distress);
- isolating himself;
- insomnia, nightmares and flashbacks.

Mr. Z was also displaced, unemployed, homeless, lonely and isolated. Regardless of whether Mr. Z had PTSD or not the NICE treatment guidance held relevance for him. People who present to mental health services as a direct result of trauma, or because of the stress of being displaced whilst seeking refugee status, cannot be treated with a medication regimen in isolation from other therapy and social care interventions. Unfortunately medication was the only treatment made available to Mr. Z. It cannot be known whether or not a comprehensive care and treatment programme would have ensued once Mr. Z had been accepted by the Community Mental Health Team. However the ward clinical team should have commenced a holistic, multidisciplinary assessment and care and treatment process that was culturally appropriate to Mr. Z's needs from day one. A number of the NICE guidelines, and certainly those for depression, indicate that psychological treatment/intervention should not be delayed until an individual is discharged from hospital.

Local Demographic Issues

One might be tempted to regard Mr. Z, his refugee status and his cultural issues as an isolated case unlikely to recur in the future. However, Mr. Z's care and treatment and the particular issues relating to it might well be viewed as a particular case study in the context of the Government's policy of dispersal of asylum seekers around the country.

It is difficult to disaggregate asylum seeker resettlement figures for the Pennine Care NHS Foundation Trust geographical area from those of national statistics as the Home Office no longer provides the data in this format on its public website. However the last available disaggregated figures were for December 2007 and showed that substantial numbers of asylum seekers had been resettled within the Trust catchment area. These figures are set out in table five below.

Table Five: Showing Asylum Seeker Resettlement Figures for 2007 in the Pennine Care NHS Foundation Trust Area[100]

Place of Resettlement in 2007	Numbers
Bury	**510**
Oldham	**480**
Rochdale	**405**
Stockport	**165**
Tameside	**235**
Total Figures	**1,795**

The figures set out above show that asylum seekers form a significant part of the Trust catchment area population, and as such will require an ongoing consideration from mental health services. Obviously these figures do not take into account the considerable numbers of people that were resettled prior to, and after, 2007.

12.1.8.3. Conclusions

Whilst on Hollingworth Ward Mr. Z did not receive appropriate consideration that took into account his cultural diversity needs and his personal history as an asylum seeker. By 2007 there was a myriad of national publications available detailing how cultural diversity issues, black and minority ethnic populations, and asylum seekers should be managed when in contact with mental health services. By 2007 the guidance in these publications should have been central to the practice of all clinical teams providing care and treatment to individuals such as Mr. Z.

The care and treatment that Mr. Z received was culturally insensitive and ensured that he was not assessed or treated in the context of either his personal history or his cultural background. This meant that Mr. Z was assessed at 'face value' only. Mr. Z's complex symptomology and presentation could have been understood better had he been assessed and treated in accordance with the Department of Health's *Delivering Race Equality in Mental Health Care* (2005) action plan, and the Department of Health's *Celebrating our Cultures: Mental Health Promotion with Refugees and Asylum Seekers* (2004). Whilst it cannot be said with any degree of certainty that this would have prevented the death of Ms. X it is probable that Mr. Z

100 http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1510.pdf

would have been cared for and treated in a more appropriate manner. This may well have alleviated some of his symptoms and reduced the high levels of anxiety and distress that contributed to his decision to kill Ms. X.

- ***Contributory Factor Number 6 (Influencing). Mr. Z was not assessed and treated within the context of his personal history and cultural background. His vulnerabilities as an asylum seeker with emergent mental health problems were not understood and Mr. Z was assessed in a culturally inappropriate manner that failed to identify his care and treatment needs.***

12.1.9. Service User Involvement in Care Planning

12.1.9.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"offer choices which promote independence"*.

12.1.9.2. Findings

It was evident that Mr. Z was interviewed at length at Rochdale Infirmary on the 1 August 2007, that he was consulted prior to his admission to Hollingworth Ward, and that he gave his consent for this to happen.

Once on Hollingworth Ward the Named Nurse assessed Mr. Z. In order to do this she spent time with him and documented that most of the information that she elicited had come directly from interviewing him.

However Mr. Z did not sign any of his care plans and it is not clear whether or not he was given his own copy of them. Neither is it clear whether the aims and objectives of the plans were discussed with him and whether or not he agreed to the interventions. It is possible that on admission Mr. Z was not well enough to engage in an active care planning session, however there is no indication to suggest that Mr. Z was ever invited to become involved in the formulation of his care and treatment plan once he had settled onto the ward. In fact from the patient progress notes it is difficult to understand whether or not any kind of interaction took place with Mr. Z at all following his admission apart from the most basic kind.

For the 13 day period that Mr. Z was on Hollingworth Ward he was subject to 15 minute observations. The Observation Record did not indicate that any kind of interaction took place during these observations, or that the observation process was in itself designed to form any kind of structured engagement programme with Mr. Z. The Observation Record routinely recorded that Mr. Z was on his bed most of the day and night, either asleep or reading. It would appear that Mr. Z was left to his own devices and that a very limited level of social engagement was attempted with him, even though his care plans advocated social engagement, the building of a therapeutic relationship and protected one-to-one time in order for him to be able to discuss his feelings.

It would also appear that no significant attempt was made to either get to know or understand Mr. Z. His quiet and polite manner, coupled with his depression and need to isolate himself, served to render him, if not exactly invisible, of low priority. It is a common occurrence on busy acute admission wards that quiet patients, who do not present pressing management problems, are often left for long periods of time with few therapeutic interventions occurring. The Independent Investigation Team offers the observation that this may have been a factor in the management of Mr. Z's case.

As has already been mentioned in subsection 12.1.8. above, Mr. Z was not appropriately assessed or understood from a cultural diversity point of view. It would also appear that from a basic service user involvement point of view Mr. Z's thoughts, views and wishes concerning his care, treatment and long-term future were not sought either. It is difficult to understand why Mr. Z was not engaged with. He was described as being polite and pleasant, he definitely did not present with aggressive or violent outbursts, or with other equally difficult to manage problems. Some witnesses felt that his ability to speak English presented

a barrier, whilst others felt that his command of the English language was good enough for him to understand and make himself understood perfectly well.

It is always difficult to try and understand how a service works when seen through the lens of a single case. However in the case of Mr. Z no attempt was made to engage with him and there were no documented attempts made to access his inner world or involve him in his care and treatment. The assessments that were undertaken were neither comprehensive nor holistic and Mr. Z appears to have been a passive recipient of the service that he was offered.

12.1.9.3. Conclusions

There is no evidence to suggest that any attempt was made to involve Mr. Z in his care and treatment whilst he was a patient on Hollingworth Ward. It would also appear that little attempt was made to engage with Mr. Z and he was left alone in his side room for most of the time. Obviously Mr. Z had the right to remain in his room if he wished to do so, however he was an informal patient and had consented to be on the ward and to receive care and treatment whilst there. Mr. Z's decision to stay in his room appeared to have been made by 'default' as no other viable alternative was either discussed with or made available to him.

The Independent Investigation Team finds in common with the Internal Review that Mr. Z was neither involved in his care and treatment nor engaged with in an appropriate manner likely to accomplish the aims and objectives of his care plans.

At the point of the incident occurring Mr. Z's wishes had not been explored with him. His hopes and fears for either the short, medium or long-term future had not been discussed with him and no active plan was in place to promote his recovery.

- ***Contributory Factor Number 7 (Influencing). Mr. Z did not receive the kind of patient-centred care that would have aided either his short-term care and treatment or long-term recovery. This served to exacerbate his isolation and ensured that he remained an unknown quantity to the clinical team.***

12.1.10. Documentation and Professional Communication

12.1.10.1. Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

The GMC states that:

'Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off[101]*,*

Pullen and Loudon writing for the Royal College of Psychiatry state that:

"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised."[102]

Professional Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[103]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone[104]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis*

101 http://www.medicalprotection.org/uk/factsheets/records

102Pullen and Loudon, *Advances in Psychiatric Treatment,* Improving standards in clinical record keeping, 12 (4): (2006) PP 280-286

103 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) P121

104 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing,* Institute of Health Services, (1999) P144.

(1994) criticised agencies for not sharing information and not liaising effectively[105]. The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required. Whilst Mr. Z did not present with high risk behaviours or a criminal record, he did present with a challenging and complex history which had necessitated the involvement of several statutory agencies.

12.1.10.2. Findings

There are two main issues examined in this subsection. They are:

- interagency liaison;
- professional documentation and communication.

Interagency Liaison

In common with other asylum seekers Mr. Z had been subject to resettlement in several different locations in the United Kingdom over a relatively short period of time. It is certain that he had been registered with three different General Practices during this period. It is also certain that the GP Mr. Z had registered with at the time of his move to Rochdale was not in possession of any of Mr. Z's previous primary care records.

Following Mr. Z's admission the Hollingworth Ward Clinical Team made a timely communication with Mr. Z's Rochdale-based GP in order to ascertain any psychiatric or medical history relevant to his current presentation. Unfortunately the Rochdale GP did not have access to important information from the previous Blackburn GP regarding Mr. Z's emerging mental health problems.

As has been mentioned above in subsection 12.1.8. *"high mobility also means that healthcare providers are often required to treat asylum seekers in the absence of medical notes, which do not follow in time."*[106] Both the Home Office and the Department of Health advocate the use of patient-held records for asylum seekers in order to ameliorate this problem. It would appear that Mr. Z did not have in his possession his own patient-held record. Neither would it appear that practitioners in primary care tried assertively to share and pass on Mr. Z's clinical records from one service to another.

105 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

106 Home Office. Asylum Seeker in Dispersal: Healthcare Issues. 2003

Documentation and Professional Communication

The Independent Investigation Team found significant issues with regards to documentation and professional communication. They were:

1. poor standards of clinical record keeping;
2. non CPA compliant documentation;
3. poor use of clinical information;
4. the lack of an integrated clinical record.

First: the standard of record keeping by the Hollingworth Ward nursing team was generally of a good standard in that it was timely, relevant and legible. The records developed by the medical team however did not meet either local policy or national best practice expectation. The Independent Investigation Team could not find any evidence of the medical team having been involved in risk assessment or Mental State Examination processes. Neither was there any evidence of a full psychiatric history having been taken. In short the records generated by the medical team were superficial and contained the most basic of clinical information. At interview medical witnesses could recall discussions that took place regarding Mr. Z. However they acknowledged that these discussions were not recorded and that the extent of what was achieved with Mr. Z might not have been reflected by what was written in the notes. All medical witnesses offered the view that they were operating within very tight time constraints and had other patients to see. It would appear that Mr. Z was not seen as presenting with any specific problems that required urgent prioritisation. One witness stated *"it seems on paper that we didn't do very much but in practice that was not the case."* [107] Unfortunately, based on the evidence available to the Independent Investigation Team, there is no way that this view could be substantiated.

Second: the documentation utilised on Hollingworth Ward in 2007 was not compliant with the requirements of the Care Programme Approach. The CPA policy extant at the time Mr. Z was a patient on Hollingworth Ward stated that locally determined documentation could be used when undertaking a CPA assessment. The documentation that was used for Mr. Z did not lend itself to the holistic assessment of health and social care needs that an effective CPA process would require. Neither did it lend itself to the identification of cultural diversity issues. It is often the case, particularly when relatively junior clinicians are involved, that

107 Witness Transcription

documentation is filled out 'to the letter,' with staff rigidly supplying only what is requested on the form. The assessment documentation format used for Mr. Z provided a relatively narrow set of healthcare-based prompts. It would appear to have been the case that because the documentation format was not comprehensive and holistic, then neither was the ensuing assessment.

Third: it was unclear when the clinical records generated at the Rochdale Infirmary arrived onto Hollingworth Ward (these notes were of an exceptionally good quality). The Independent Investigation Team were unable to interview the doctor who undertook the assessment at the Accident and Emergency Department on the afternoon of the 1 August 2007, however the Internal Review Report stated that this individual came onto Hollingworth Ward the evening that Mr. Z was admitted and provided a verbal handover to the ward nursing staff.[108] At this point enough information was known about Mr. Z to commence an assessment which was conducted by the Named Nurse, and whilst she was operating within the constraints set out in the paragraph directly above, this was done in a competent manner. The question here is, how well was this clinical information kept up-to-date and how widely was it shared with the rest of the multidisciplinary team?

It cannot be known what exactly was discussed at the ward round on the 2 August 2007, or by whom, as this was recorded poorly in the clinical notes. However clinical witnesses when interviewed by the Independent Investigation Team were of the view that not very much was known about Mr. Z at this juncture. The medical team described the practice of relying upon the nursing staff to 'flag up' any potential issues of relevance. The medical team also stated that it was not common practice to read clinical notes because a verbal handover, principally from nursing staff, was the preferred method of clinical communication. It was evident that the Accident and Emergency records were sent to the ward prior to the incident occurring, but no one appears to have read them until after the death of Ms. X. Medical witnesses expressed surprise at the amount of information that had been available to them in Mr. Z's clinical record. One medical witness said *"I was shocked by the amount of information in there which would point to something serious happening. But again you don't get that flavour just listening to the verbal reports."*[109] Unfortunately it is not clear who knew what, or when, and how this information was communicated. Neither nursing nor medical staff could identify the

108 Internal Review Report P33
109 Witness Transcription

process that the multidisciplinary team deployed in order to ensure that appropriate communication would occur.

Fourth: at the time of the incident the clinical records on Hollingworth Ward were not integrated. In practice this meant that nursing and medical notes were kept separately with neither professional group routinely accessing the notes of the other. This was exacerbated by the absence of an electronic patient record system which could serve as a central professional communication access point. At the time Mr. Z received his care and treatment from the ward clinical information was shared verbally. What was shared depended upon the experience, knowledge and judgement of the person making the verbal report. It would appear in the case of Mr. Z this method was not effective in the communication of either his mental state, risk or need.

12.1.10.3. Conclusions

Interagency Liaison

It was evident that Mr. Z, in common, with other asylum seekers, lived in several places prior to his admission to Hollingworth Ward. It was also evident that his primary care records did not follow him as he moved from location to location. It is not clear why this was the case, and neither is it clear why Mr. Z was not given a patient-held clinical record. Regardless of the reasons, the learning here is; people like Mr. Z are rendered vulnerable when significant information about them is not made available when required. Mr. Z represents a 'worked model' of what the Home Office has been trying to address since 2003. It cannot be known whether the primary care-held knowledge about Mr. Z's emerging mental health problems would have substantially influenced his care and treatment on Hollingworth Ward. However, regardless of whether this would have been the case or not, it was information that did not follow the patient and should have.

Documentation and Professional Communication

Clinical records form an essential part of the professional communication process. The Independent Investigation Team conclude that both Trust-wide service systems and local custom and practice issues were at play in ensuring Mr. Z's clinical information was not managed or utilised appropriately.

Trust-wide service systems did not ensure that the clinical records on Hollingworth Ward were integrated in line with national best practice guidance. Integrated patient records have been both an expectation and a requirement for healthcare providers for the past decade.[110] The absence of an electronic patient record system exacerbated the communication difficulties caused by the development and maintenance of uni-professional records.

The lack of a Trust-wide CPA documentation format led to poor practice in the assessment of Mr. Z. This made a direct contribution to his needs being only partially identified and to his situation not being fully understood.

Local custom and practice lent itself to a culture of verbal, rather than written, communication. Whilst good verbal face-to-face communication is to be commended, it should not have become a substitute for written communication and record keeping. It was evident that clinical team members did not appear to either read clinical records or routinely write in them. As a result essential clinical information about Mr. Z, which witnesses acknowledged as being of high relevance, was not taken into consideration in a timely manner. Had this been the case then his care and treatment could have been managed differently and his mental illness could have been managed more effectively. In this respect the Hollingworth Ward clinical team, and the medical practitioners in particular, failed to comply with the basic best practice requirements of their registering bodies. Relevant clinical information relating to Mr. Z was not collated, assessed or discussed in a dynamic manner. This ensured that Mr. Z was assessed, managed and treated in the absence of the full set of information available to the team at the time.

When forming conclusions the Independent Investigation Team have to consider what *was* known about Mr. Z at the time and what *should* have been known about him. Whilst taking into account the less than perfect systems that were in place, the Independent Investigation Team conclude that the doctors and nurses responsible for Mr. Z's care and treatment had in their possession significant information that they did not act upon. Communication processes were not robust enough to ensure that relevant clinical information was identified, discussed and incorporated into a dynamic care and treatment plan. As a result Mr. Z did not receive the care and treatment that he required.

110 Department of Health and Clinical Negligence Scheme for Trusts

- ***Contributory Factor Number 8 (Influencing). The decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Clinical Team at the time. As a result Mr. Z did not receive the care and treatment that he required.***

12.1.11. Overall Management of the Clinical Care and Treatment of Mr. Z

This subsection serves to examine the overall impact of the care and treatment Mr. Z received upon his mental health and continued wellbeing. This subsection also serves to summarise the clinical findings set out in subsections 12.1.2 -12.1.10. above.

12.1.11.1. Findings

Care and Treatment

Subsections 12.1.2.-12.1.10. set out the main issues that were pertinent to the quality of the care and treatment that Mr. Z received from the Pennine Care NHS Foundation Trust. When examining these issues the Independent Investigation Team had to consider whether or not they constituted a direct causal link between the quality of the care and treatment that Mr. Z received and the death of Ms. X.

Eight factors have been identified by this Investigation that made a direct contribution to Mr. Z's mental illness remaining unabated. The criminal justice system process made a direct causal link between the death of Ms. X and the mental illness of Mr. Z.

However when examining a case of this kind it is often difficult to understand whether any act or omission on the part of a mental health service (in this case the Hollingworth Ward clinical team) had any direct causal bearing upon the actions of an independent third party (in this case Mr. Z).

The safe and effective delivery of clinical services requires that basic building blocks of care are put into place. In the case of Mr. Z these basic building blocks should have consisted of:

- taking a psychiatric history;
- conducting a Mental State Examination;

- agreeing a diagnosis;
- undertaking an assessment of risk;
- undertaking an assessment of need;
- developing care and treatment plans;
- initiating a medication regimen as appropriate;
- ongoing monitoring and assessment;
- development and maintenance of therapeutic relationships;
- maintenance of a safe and therapeutic environment;
- clinical communication and liaison.

It should be taken as read that these basic building blocks of care s*hould* have been provided within an ethos that was service-user centred and culturally appropriate.

When considering the above-listed basic building blocks of care it became evident that this 'bedrock' of clinical service delivery failed to work effectively in the case of Mr. Z. It is not necessary to repeat in-depth all of the findings that have been detailed in the previous subsections above. However to summarise:

- no psychiatric history was formulated and Mr. Z remained an unknown quantity for the entire 13 days he stayed on Hollingworth Ward;
- assessment of both risk, mental state and need was incomplete and was not based on everything that was known about Mr. Z;
- care and treatment was not delivered in either a timely or consistent manner.

Mr. Z *did not* receive his care and treatment in an environment that was service-user centred or culturally appropriate. Over the 13 day period that he was on Hollingworth Ward his mental illness went unabated and his distress and anxiety continued to build.

Multidisciplinary Team Working

The care and treatment issues that have been identified need to be considered within the context of the multidisciplinary team. A multidisciplinary team is at its most basic a clinical service delivery unit. Service users should be able to access care and treatment from a wide-ranging group of clinical experts who can deliver a comprehensive and evidence-based care and treatment regimen.

A multidisciplinary mental heath team (MDT) is not simply a network of individuals each fulfilling his/her own role and carrying out his/her own tasks. A multidisciplinary team is a groups of individuals from a range of professions brought together to achieve a common goal in an effective and coordinated manner. Each professional group brings to the process a set of skills, a particular expertise, a knowledge base and a point of view. This expertise, and the emphases of the disciplines making up the MDT, are brought together to realise a comprehensive assessment, formulation and care plan for an individual. This said, a basic requirement of an effective MDT is that it is made up of a relevant and adequate set of individuals from appropriate professional disciplines.

Composition of the Clinical Team

The clinical team caring for Mr. Z on Hollingworth Ward was made up of only two disciplines: nursing and psychiatry. The need for a holistic assessment has been discussed above. The provision of adequate care and treatment for Mr. Z would have required access to: occupational therapy to assess his longer-term needs and to identify how he might be beneficially engaged during his time on the ward; social workers to consider his social care needs; and psychology to help understand Mr. Z's problems from a psychological perspective.

Team Coordination/Team Working

The clinical team on Hollingworth Ward did not function as a single multidisciplinary team but rather as two uni-disciplinary teams which shared the care of Mr. Z. The role of the nursing team appeared to be to provide care for Mr. Z and manage the environment in which this care was delivered. The role of the medical team appeared to be to initiate and prescribe pharmacotherapy (medication). Whilst these two contributions were essential, they were not enough on their own to deliver a comprehensive care and treatment package to Mr. Z.

Clinical Leadership

In was not clear to the Independent Investigation Team who provided the clinical leadership to the clinical team at the time Mr. Z was an inpatient, either for the team in general or with respect to Mr. Z's care in particular. For example, it was not clear whether any individual had the responsibility of ensuring that all relevant information was collected, collated and brought to the attention of the team when (clinical) decisions were being made, of ensuring that a

coordinated and focused assessment was undertaken which informed (clinical) decision making, or of providing appropriate supervision to the Named Nurse to ensure that the care plan (which she drew up following her assessment) was practicable and would meet Mr. Z's identified needs.

The Department of Health published its *New Ways of Working for Everyone* in 2007 and as part of this initiative published guidance on creating effective multi-disciplinary teams: C*reating Capable Teams: Best Practice Guidance to Support the Implementation of New Ways of Working.* These documents might usefully be employed to inform the development and functioning of the multidisciplinary team on Hollingworth Ward and elsewhere in the Trust.

Understanding the Patient

The notion held by the medical team that Mr. Z's condition could be understood by assessing him as a homeless person from Leopold Court was a mistaken one. Medical witnesses told the Independent Investigation Team that they believed Mr. Z presented in a manner that was in no way unusual for a person being referred from Leopold Court. The assumption that Mr. Z's problems derived from his 'homeless' condition was superficial when considered against the backdrop of what was already known about him at the point of his admission.

12.11.2. Conclusions

The failure to provide the basic building blocks of care ensured that Mr. Z's psychiatric condition was only partially treated. Mr. Z's presentation was such that a serious untoward incident of some kind was foreseeable, during his admission his risk of suicide had led to 15 minute observations being set by the nursing team. He had stated clearly his perspective on his situation on the 1 August 2007 as requiring that he either had to kill himself or someone else in order to resolve his predicament. Whilst on Hollingworth Ward he consistently maintained the view that he wanted to hang himself.

There were some actions that were undertaken by the clinical team that were considered by the Independent Investigation Team to have been good practice. They included:

- the thorough initial risk assessment that was commenced on the day Mr. Z was admitted, and completed the following day;

- the decision to place Mr. Z on 15 minute observations;
- the development of sound initial care plans.

However on examination of this case it was evident that Mr. Z did not continue to receive either a timely or an effective service from his clinical team. This was noted to be of particular significance when the care and treatment that Mr. Z received from the medical members of the team was reviewed.

It is the finding of the Independent Investigation Team that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Z and his untreated and deteriorating mental state. When examining the effectiveness of care and treatment it is reasonable to assume the following:

- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;
- risk management and treatment plans can reasonably be expected to reduce risk and to improve mental health.

His Honour Judge Gilbert Queen's Counsel on sentencing Mr. Z made a direct link between his mental illness and the death of Ms. X.[111] This Investigation found a direct causal link between the care and treatment that Mr. Z received and his partially treated and deteriorating mental state. The sentencing Judge made the causal link between his mental state and the death of Ms. X.

In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used in this report to describe an act or omission that the Independent Investigation Team have concluded had a direct causal bearing upon the failure to treat and manage Mr. Z effectively. Subsequently forensic experts and the Crown Court found Mr. Z's abnormality of mind to have impacted directly upon the death of Ms. X. A causal factor is recognised as being a factor over which a service provider had a significant degree of control. It was within the control of the service to have provided a substantially

111 Court Transcription 27 April 2008 P1

better level of care and treatment to Mr. Z. As a consequence Mr. Z's mental illness continued unabated. It was the ruling of Judge Andrew Gilbert at the Manchester Crown Court that at the time of the killing of Ms. X Mr. Z was *"suffering from a severe illness"* and that this illness directly led to his decision to kill.

This finding of causality has not been assigned either due to the seriousness of the incident or its consequences. Neither has it been assigned using the benefit of hindsight. The test used has had to consider what the root cause of Ms. X's death was. This has been determined in a court of law as being due to the actions of Mr. Z who killed her as a direct result of his paranoid schizophrenia. Causality has been assigned to the Trust during this Investigation because at the time of incident:

- Mr. Z and Ms. X were receiving inpatient care and treatment from a statutory body;
- Mr. Z did not receive an appropriate level of assessment to determine his needs in the context of his background and his illness;
- Mr. Z did not receive an appropriate risk assessment that was dynamic and took into account the risks that he presented either to himself or to others;
- Mr. Z received neither a timely nor effective care and treatment package to address his mental health problems.

The above bulleted factors were all factors over which the clinical team had a high degree of influence. It was apparent to this Investigation that the basic building blocks of care were not put into place appropriately, and the actions that the clinical team had within its legitimate power to initiate were not carried out.

An Investigation of this kind is not about apportioning blame. It is about learning lessons.

Corporate Learning. It is not possible to state with certainty whether systems and procedures failed to operate when seen through the lens of single case that was open to the Trust for a total period of only 13 days. However as part of this Investigation the Independent Investigation Team examined the Trust current governance systems and processes and found them to be of a high standard. The tragic death of Ms. X was not found to be due to inherent failures in the Trust clinical governance system, even though it did not appear to have been robust enough during 2007 to detect relevant clinical departures from best practice. Whilst

aspects of the ward environment were seen to require immediate remedial action by the Internal Review Team, these actions were advised due to being assessed as good practice rather than through being identified as direct causal factors in the death of Ms. X. The Independent Investigation Team would concur with this view. Two other issues were identified by the Independent Investigation Team, these were:

1. the lack of clinical record integration;
2. the lack of multidisciplinary team working.

The Independent Investigation Team was told that both of these issues were due to be addressed in February 2011. The first by the introduction of the Trust electronic record system, the second by the introduction of *New Ways of Working*. There will remain however an issue regarding the funding/availability of occupational therapy and psychological therapy inputs.

Corporate Learning needs to focus upon the importance of audit and monitoring processes to assure the Trust Board that clinical systems are in place and are being implemented appropriately. The introduction of the electronic record and *New Ways of Working* will require ongoing monitoring and review, especially during the first year of implementation.

Team Learning. The clinical team did not fulfil its duty of care to Mr. Z and by extension to Ms. X. Once again it is not possible to make generalisations based upon the examination of a case that was open to the team for a period of only 13 days. It is possible had the incident not occurred when it did that the care and treatment issues would have resolved and appropriate assessment, care and treatment would have followed. However based on what was known at the time, and what should have been known at the time, the interventions made by the team were collectively inadequate.

Individual Learning. Registered professionals have distinct responsibilities when delivering care and treatment. These responsibilities require that each professional:

- reads all relevant clinical information in a timely manner;
- conducts comprehensive and timely assessments;
- formulates care and treatment plans;
- implements care and treatment plans;

- records diligently;
- communicates clearly and effectively with other team members;
- ensures that assessment, care and treatment are conducted in a culturally appropriate manner.

It was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Z and his untreated and deteriorating mental state. When examining the effectiveness of care and treatment it is reasonable to assume the following:

- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;
- risk management and treatment plans can reasonably be expected to reduce risk and to improve mental health.

Summary

Had the clinical team provided a better standard of care and treatment there could still have been no absolute guarantee that the serious untoward incident would have been prevented. However had the clinical team carried out every action that was reasonably within its gift then the Department of Health adage of *"as long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time"* would have held. It was evident that the overall management of Mr. Z's case could, and should, have been managed in a more robust manner. It should be noted that no matter how many contributory factors of an influencing kind are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party. In this case it was the conclusion of the Investigation Team that the Swiss Cheese Model, as described on page 66, best describes the chain of causality. Had the care and treatment been managed to a significantly better standard and evidence base, then it could reasonably be expected that Mr. Z's mental state and associated behaviour would have been both managed safely and ameliorated.

His Honour Judge Gilbert Queen's Counsel on sentencing Mr. Z said *"in a modern society those who suffer from the affliction of mental illness or disorder must be treated with the same sympathy and care as attends those suffering from any other illness…I am satisfied on*

the evidence that you were suffering from paranoid schizophrenia in a particularly severe form. It led you to kill your victim…I have already approved the prosecution course that you are convicted of manslaughter by reason of diminished responsibility, as you plainly were."[112] This Investigation found a direct causal link between the care and treatment that Mr. Z received and his untreated and deteriorating mental state. The sentencing Judge made the causal link between his mental state and the death of Ms. X.

- ***Contributory Factor Number 9 (Causal). The level of care and treatment that Mr. Z could reasonably have been expected to receive was not delivered. Risk management and evidence-based care and treatment can reasonably be expected to improve mental health and reduce risk. This factor was under the direct control of the clinical team and therefore the team retained a high degree of influence over the mental health of Mr. Z and thereby the circumstances that led to the killing of Ms. X.***

12.1.12. Resuscitation Processes

12.1.12.1. Context

At the time of the incident the Trust had a comprehensive and evidence-based resuscitation policy in place. The Internal Review found that *"although there is an exceptionally high number of staff who have recently trained in basic life support techniques, some bank staff had not received this training."* [113]

The extant resuscitation policy in place at the time of the incident stated that *"there is no cardiac arrest team at the Birch Hill Hospital site therefore staff are reliant on a paramedic response to an emergency: staff must ring 444 to be put through to GMAS".* [114]

112 Court Transcription 27 April 2008 P1
113 Internal Review Report P35
114 Resuscitation Policy P9

12.1.12.2. Findings

Description of Immediate Events

The following account has been taken from the transcription of the Manchester Crown Court proceedings of the 2 November 2007, and witness statements and interview transcriptions generated by this Independent Investigation.

On Monday 13 August 2007 at approximately 17.20 hours a staff member found Ms. X collapsed on the floor of the female lounge on Hollingworth Ward. The staff member activated a fob alarm in order to summon help. Immediately on hearing the alarm the Ward Sister rushed to the female lounge to find two members of staff already present trying to awaken Ms. X. At this stage Ms. X appeared to be unconscious. There was blood at the corner of her mouth, but she seemed to be breathing *"very slightly".*[115] At this stage Ms. X was observed to have blue lips and a pale complexion.

The oxygen cylinder and basic life support equipment was collected from the clinic room. At this stage Ms. X was thought have a faint pulse. The Ward Sister ran to the office to telephone the On Call Doctor. At exactly 17.32 the Ward Sister called for an ambulance. Following this, the Ward Sister called the Ward Manager to tell him what was happening and to ask for his presence with immediate effect.

Whilst the Ward Sister was summoning external assistance, the rest of the ward team had commenced cardiac pulmonary resuscitation procedures on Ms. X as it appeared her pulse was absent. The On Call Doctor, the Ward Manager and other staff from a neighbouring ward who had responded to the alarm arrived promptly and cardiac pulmonary resuscitation procedures were continued. As it was evident that Ms. X had no cardiac output a defibrillator was used. However no heartbeat or rhythm was found and cardiac pulmonary resuscitation procedures continued.

At 17.40 the Ward Sister made another call for ambulance assistance as no ambulance had yet arrived at the scene. The ward staff continued in their attempts to resuscitate Ms. X.

115 Manchester Crown Court Transcription. 2 November 2007. P.1.

At 17.45 hours the ambulance crew and paramedics arrived and took over from the ward team. At 18.06 hours the ambulance crew left Hollingworth Ward with Ms. X for the Rochdale Royal Infirmary. They arrived at 18.12 hours and Ms. X was declared dead shortly afterwards.

Summoning the Ambulance Service

At 17.32 hours the first call to the North West Ambulance Service NHS Trust was made. The ambulance log recorded *"59 year old female collapsed to be taken to Rochdale Infirmary."* No further clinical information was provided so this 999 call was treated as a hospital transfer and coded as a 'Green' response. The Ambulance Service has to respond to a 'Green' call within one hour. At this point there was an ambulance sitting outside of Hollingworth Ward on the Birch Hill site that could have responded to the call. However this ambulance was called away to another incident that had received a more highly prioritised summons.

At 17.40 hours the second call to the North West Ambulance Service NHS Trust was made. The ambulance log recorded *"female patient not breathing and not conscious."* This call was treated as a patient in cardiac arrest and was graded as a 'Purple' response. The Ambulance Service should aim to respond to a 'Purple' call within eight minutes.

At 17.45 hours the ambulance arrived at the scene. The Internal Review stated that *"the ambulance response was delayed because the satellite navigation system picked up the post code which took them to the wrong part of the Birch Hill Hospital Site."* [116] The Internal Review considered this to be an important issue that required remedial action as it applied to all 'blue light' services which may be required to respond to emergencies on the site in the future. Recommendation 29 from the Internal Review Report stated that *"the routing of the emergency services to the correct part of the Birch Hill Hospital Site is being addressed but requires an early resolution".* [117]

Care of Other Ward Service Users and Mr. Z During the Cardiac Pulmonary Resuscitation Procedures

It was evident from the examination of the court transcription, witness statements and witness transcriptions to the Independent Investigation that every effort was made to support the

116 Internal Review P38
117 Internal Review P51

service users on the ward during the resuscitation procedure. Senior ward staff managed to maintain the safety of the ward, and also the safety of Mr. Z during this very challenging incident. This was no easy task as one of the service users who was an inpatient at the time of the incident was very disturbed, and Mr. Z required 2:1 observation until the Police arrived to escort him from the ward. The safe management of the ward was achieved in a competent and professional manner.

12.1.12.3. Conclusions

A sudden death on an acute inpatient psychiatric unit, whilst not a unique event, is an uncommon event. Whilst the resuscitation attempt on Ms. X was sadly unsuccessful, it should not deter from the fact that the ward staff acted in an exemplary manner. The resuscitation process was managed with efficiency and professionalism, made more notable by the fact that the ward team also had to continue its care and management of Mr. Z and the other service users on the ward. The Independent Investigation Team have identified this as notable practice.

The delay to the ambulance crew arriving on the ward has to be understood. From the first telephone call at 17.32 hours, to the arrival of the ambulance crew on the ward at 17.45 hours took 13 minutes. An ambulance service is required to respond to 'Purple' calls within eight minutes 75% of the time.

There are two issues here. First: the confusion that clearly existed regarding the status of the first call which was incorrectly coded a 'Green'. Second: the view of the Internal Review that delays were caused by problems with the satellite navigation system that directed the ambulance to wrong entrance, thus causing a delay. It must be noted here that the Internal Review Team did not involve the North West Ambulance Service NHS Trust in the internal investigation process.

First: it was evident that the Ward Sister believed that she was summoning an emergency ambulance when she made the first 999 call at 17.32 hours. This was not the case. It was only once the second call was made at 17.40 hours that sufficient information was given to grade the response, this time correctly, as 'Purple'. Once this had occurred the ambulance crew arrived at the scene within five minutes. This 'colour coding' system is not something that is widely known about or understood. Healthcare professionals and lay people alike often

assume a 999 call is a universal action that will always trigger a rapid emergency response. It is a point of significant learning for all healthcare professionals requiring support from emergency services that the correct information must be given in order to elicit the most appropriate and timely response.

The Independent Investigation Team discussed this issue with both the North West Ambulance Service NHS Trust and the Pennine Care NHS Foundation Trust in order to put into place a protocol with immediate effect to guide all clinicians who may find themselves in a similar situation in the future. It must be stressed here that the Independent Investigation Team does not seek to attach blame to the Ward Sister in any way. On the whole her management of the incident was exemplary. This situation has raised an inherent flaw in the system that has now been corrected.

What was not so clear however was why the resuscitation policy was not followed and a 444 emergency procedure not requested. Sub section 12.2. below examines the care and treatment that Ms. X received in the weeks prior to her death. During these weeks emergency ambulances were called on several occasions on her behalf following suspected cardiac arrests or serious events. It would appear that a mixture of 999 and 444 requests were made for an emergency response. It was evident that the ward staff did not routinely adhere to any one particular process. This is regrettable and represents a degree of confusion in the minds of the Birch Hill site staff regarding correct procedure.

Second: the Internal Review identified an issue regarding satellite navigation systems and the poor routing of the ambulance to the ward. When the Independent Investigation Team met with the ambulance service they believed that this issue had not been raised with them. It remains unclear from where this notion arose. The Trust has stated that *"the Estates Department have entered into discussion about the Birch Hill Hospital post coding used in the satellite navigation system which currently sends people to the Union Road entrance of the hospital site. The site where the current mental health services are based is on Birch Road not Union Road".* It is unclear what progress has been made regarding this issue, and it underlines the conclusions in subsection 12.1.1. regarding the need to make formal the arrangements between the Trust and Emergency Services.

Once again the Independent Investigation Team would like to state that in the weeks prior to Ms. X's death an emergency ambulance was called to Hollingworth Ward on several occasions. At no time did they appear at the wrong hospital entrance.

It cannot now be known whether or not the more timely arrival of the ambulance crew at the scene of the incident could have altered the outcome. Taking the Post Mortem report into account it would appear that this would have been unlikely. There are no contributory or causal factors identified with regard to this subsection. However there is a service issue in that emergency arrangements should be of a formal nature and that protocols and procedures need to be clear, and understood, by all statutory agencies and the staff who work within them.

- ***Service Issue Number Two. An inherent system failure was identified as the result of the Independent Investigation regarding the procedure required to call an ambulance for assistance to emergency situations. It was evident that there was confusion with regard to the emergency call out system in that a combination of 999 and 444 procedures were interchangeably used.***

12.1.13. Clinical Supervision

12.1.13.1. Context

There has been a growing interest in and awareness of the importance of clinical supervision in all health and social care professions over the past two decades, particularly in mental health professions. There are guidance documents from registration and professional organisations [118] which stress the importance of supervision for clinical governance, quality improvement, staff development and maintaining standards.

The NHS Management Executive defined clinical supervision in 1993 as:
'...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations'[119]

118 Nursing and Midwifery Council. (2008) Clinical supervision for registered nurses
119 Nursing and Midwifery Council, Advice Sheet C. (2006)

Clinical supervision is used in counselling, psychotherapy and other mental health disciplines. Supervision provides the opportunity to discuss case work and other professional issues in a structured manner. In the United Kingdom clinical supervision has been seen by both the Department of Health and the statutory healthcare professional regulatory bodies as an integral part of professional health and social care practice since the early 1990's.

Pennine Care Clinical Supervision Policy 2007

There was an appropriate and fit for purpose clinical supervision policy in place at the time Mr. Z was receiving his care and treatment on Hollingworth Ward (version 1 HR 23). This policy, appropriately, made the distinction between the function and purpose of management and clinical/professional supervision. The expectation was for Trust non-medical clinical staff to receive supervision on a monthly basis.

The policy aimed to make provision for 1:1 supervision to take place but acknowledged that this would not always be possible and that group supervision may have to be deployed. The Trust stance was that it *offered* supervision to existing staff and would *require* it when engaging new staff at the point when contracts of employment were agreed.

12.1.13.2. Findings

At the time of the incident the Internal Review found that clinical supervision was not accessed by *"most of the staff on the ward".*[120] This was for a variety of reasons and included the lack of available supervisors and issues with regard to service replacement time allowing for people to leave the ward. There was also a view amongst many of the ward staff that they did not require supervision and therefore they made no effort to receive it.

When the Independent Investigation Team visited the ward in November 2010 it was evident that a clinical supervision process was in place. However the Independent Investigation Team was also told that there were still difficulties in the delivery of clinical supervision as many staff remained uncertain as to its value and did not present themselves for it. Whilst each Trust employee receives an annual appraisal review that addresses performance and training and development issues, it would appear that not all staff routinely receive supervision on a regular basis, especially if they are unqualified workers.

120 Internal Review P35

12.1.13.3. Conclusion

Clinical supervision is a recognised process that underpins safe and effective therapeutic working and is an essential part of promoting reflective practice. It was evident that Hollingworth Ward has developed a sensible current approach to supervision but that some staff are still non-compliant with it.

It is difficult to understand whether or not the lack of supervision *per se* contributed to the poor overall management of Mr. Z. The Independent Investigation Team would concur with the findings of the Internal Review that it probably did not, and would also support the recommendation that was made by the Internal Review Team in that *"the Trust should radically revise its arrangements for access to and provision of clinical supervision on a regular basis for all staff working in acute services".* [121] Whilst the Independent Investigation Team acknowledge that a great deal of work has been done to revise supervision arrangements more still needs to be done to ensure a 100% take up.

- ***Service Issue Number Three. Poor clinical supervision practice was evident on Hollingworth Ward at the time Mr. Z received his care and treatment.***

12.1.14. Adherence to Local and National Policy and Procedure

12.1.14.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."* [122] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to

121 Internal Review P.50
122 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) P 328

their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.15. below.

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.14.2. Findings

Quality of Local Policies and Procedures

The Independent Investigation Team found the clinical policies and procedures of the Pennine Care NHS Foundation Trust to be of a high standard. These policies and procedures were evidence-based and in keeping with national best practice expectation.

The only exception to this was in the case of the Care Programme Approach Policy (CPA) in place at the time Mr. Z was receiving his care and treatment, in that Trust services were able to determine locally the documentation that was used to conduct CPA assessments. In the case of the assessment conducted on behalf of Mr. Z, on Hollingworth Ward, inappropriate documentation influenced negatively the comprehensive nature of the assessment that was conducted.

Non Adherence Issues

There were three specific policy non-adherence issues identified. These were in relation to:

- the maintenance of the clinical record;

- clinical assessment, including risk assessment;
- cultural diversity.

It was evident on the examination of Mr. Z's case that clinical records were not maintained appropriately by the medical staff and that clinical assessment and risk assessment was neither comprehensive nor dynamic. It was evident that some individual practitioners understood their roles poorly in relation to these practices, whilst others thought that either they, or their professional group were somehow exempt. The notion of exemption was a medical view (which was ascertained during witness interviews with the Independent Investigation Team) with regard to using Trust risk assessment policies, procedures, tools and recording formats.

There were many other examples of both practice and professional decision making that were poor in relation to the care and treatment that Mr. Z received. As is often the case in an investigation of this kind, these examples were found to have fallen largely within a 'sub-audit' category. The term 'sub-audit' has been used to describe practices that do not necessarily appear in policies and procedures, usually because they are such basic building blocks of care that they are not thought necessary to be included. These basic building blocks have been set out in subsection 12.1.11. above. These basic building blocks of care include:

- the taking of a psychiatric history;
- getting to know the patient and building up a therapeutic relationship;
- maintaining sound multidisciplinary communication;
- reading clinical information in a timely manner.

'Sub-audit' issues are often so fundamental that they are neither set out in policies or procedures, nor as the term suggests, audited. These issues are often cultural, and as such they are difficult to detect and difficult to change.

Adherence to National Best Practice Guidelines

It has already been noted above in subsections 12.1.2., 12.1.3., 12.1.8., and 12.1.9. that the clinical team did not follow national best practice guidelines when delivering care and treatment to Mr. Z. The findings will not be repeated again here.

12.1.14.3. Conclusions

Local Policies and Procedures

The Independent Investigation Team found the Trust clinical governance practices to be good, (please see the subsection directly below). It may seem a contradictory statement to make considering that some policy adherence was poor on Hollingworth Ward, and that some 'sub-audit' practice and clinical decision making was poor.

However the Trust fulfilled its corporate responsibility in the development and provision of fit for purpose policies and procedures. It remains unclear how much training clinical staff received in order to support the implementation of clinical policies and procedures and how these were disseminated to the staff as people found it difficult to remember how things worked in 2007. When the Independent Investigation Team visited the ward, all relevant clinical policies and procedures were on the ward and easily available to staff. There are significant areas of learning for individual practitioners regarding the custom and practice of routine care and treatment delivery. Registered professionals are required to both implement *all aspects* of Trust policy and procedure *and* to adhere to professional codes of conduct standards which set out the requirements for the provision of the basic building blocks of care.

Pennine Care NHS Foundation Trust had fit-for-purpose policies in place that reflected national best policy guidance. These policies and procedures were evidence-based and were considered by the Independent Investigation Team to be of a very high standard. What cannot be so easily understood is why certain clinical policies and procedures had not been adhered to. It was made evident to this Investigation that audit systems are currently being developed, and that at the time of the incident may not have been sophisticated enough to determine non adherence issues. Since the incident the Trust has continued to develop better governance systems to ensure compliance with policy throughout the Trust. The electronic record system introduced early in 2011 will also facilitate the audit of both clinical policy compliance and the quality of clinical inputs.

Adherence to National Best Practice Guidelines

It was evident that the national guidelines relating to Post Traumatic Stress Disorder, cultural diversity, and the care and treatment of asylum seekers was neither understood nor adhered to. It has been recognised by both the commissioner (NHS Heywood, Middleton and

Rochdale) and the Trust that the catchment area is increasingly required to understand the mental health needs of refugee populations. This lack of understanding made a significant contribution to the poor standard of care and treatment Mr. Z received and represents a significant point of learning.

- ***Contributory Factor 10 (Influencing): the Trust policies and procedures were found to be of an excellent quality, however adherence to them was found to be poor with regard to clinical record keeping, clinical assessment (including risk assessment) and cultural diversity. National best practice guidelines pertinent to the management of Mr. Z were neither understood nor followed.***

12.1.15. Clinical Governance and Performance

12.1.15.1. Context

"*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish*".[123]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Z was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

[123] Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Ms. X. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Z received.

12.1.15.2. Findings

Independent Performance Ratings

In 2007 the Trust reorganised its clinical governance processes. This change took place during the time that Mr. Z was receiving his care and treatment from Hollingworth Ward. During this period (1 April 2007 - 31 March 2008) the Care Quality Commission rated the Trust as 'Excellent' for quality of services.

In 2008/09 Pennine Care NHS Foundation Trust was rated amongst the 44 highest performing Trusts by the Care Quality Commission (CQC), and continued to be rated as 'Excellent' for services.

Clinical Governance Review

As part of its terms of reference and in fulfilment of the requirement in HSG (94)27 to restore public confidence, the Independent Investigation Team asked Pennine Care NHS Foundation Trust to provide an up-to-date account of its clinical governance structure. The following is an extract from their statement to the Team and represents the Trust view of current arrangements. The Independent Investigation Team has been able to work with the Trust in order to verify this account.

Ward to Board Culture

Pennine Care NHS Foundation Trust has embraced the ethos of a ward to board culture and has embedded Governance across the organisation. The Trust operates an integrated governance model to assure both quality and patient safety is maintained. The Trust has also adopted service line management models for service delivery and a key emphasis of this approach is clinical engagement and clinical leaders driving the Trust's strategy and care delivery.

The integrated governance model underpinning a ward to board culture includes the following notable best practice examples.

- A meeting structure from local services up to the Board with shared terms of reference and dashboard reporting;[124] the Trust has local governance arrangements feeding into a Divisional Integrated Governance Group, these groups report into the Trust's Integrated Governance Group, which is chaired by the Chief Executive and is a formal sub-committee of the Board.
- The Integrated Governance Group oversees all corporate and clinical governance, bringing together safeguarding, serious untoward incident reporting, complaints, litigation, learning and development, risk management, risk register, health and safety, infection control and all relevant aspects and Care Quality Commission requirements to maintain patient safety. Non-executive directors attend the meeting and have open invitations to attend any of the feeder meetings or to scrutinise any aspects of governance.
- The Divisional Integrated Group follows the same structure and its membership is made up of local service management and clinical leadership. This group ensures action is taken locally to address concerns, to drive service improvement and to ensure the Board is aware of issues of concern or risk.
- The Deputy Director of Nursing and lead for integrated governance co-ordinates all of the clinical governance activities and has a dynamic role working with service directors and local governance leads to ensure effective governance is in place. This role works closely with the Head of Corporate Governance to ensure complaints, litigation, legal and coroner inquests are linked to clinical governance in services.
- The Trust has developed a Patient Safety Improvement Group which has clinical and corporate membership and meets weekly to review all serious untoward incidents (grades 4 and 5). Its aim is to ensure that learning is identified to improve systems and the quality and safety of patient care.
- Learning points from SUIs are shared with the Integrated Governance Group, the Divisional Integrated Governance Group and wards/teams.
- A more detailed quarterly report is published and fed through the groups highlighted above and focuses on the lessons learnt, root cause analysis, complaints and audit reports.
- These themes are then incorporated into the training and development plan via the Educational Governance Group.

[124] "dashboard reporting" refers to systematic reporting of key performance indicators and is a tool for senior managers to monitor performance

- The Trust has also developed and published its quality accounts which outline the key quality indicators to ensure continuous improvement within services. These indicators are prioritised around the key areas of safety, effectiveness and patient experience and improvements are monitored via the integrated governance group, the quality group, and the divisional governance groups in collaboration with the wards.

The Trust Board receives a monthly integrated governance dashboard and quarterly detailed reports. In addition the Board has development sessions and training on areas such as health and safety, child safeguarding, Care Quality Commission standards and quality and patient safety. In addition to this the Board will have regular updates on the risk register and scrutinise items on this register. In 2010 the Board had two main development sessions focusing on the recommendations of the Francis Inquiry and agreeing an action plan to respond to those recommendations.

Finally, the Board (both Non Executive Directors and Executive Directors members) participate in a Trust-wide clinical presence programme. This coordinated programme timetables attendance by Board members to service visits and to spend time with clinicians. This is to ensure the Board is visible, meets staff regularly and hears direct accounts of the challenges clinicians face in practice. As a consequence these visits are discussed at Board and in Executive Director meetings and where needed actions are progressed as a direct response to issues raised by staff.

Staff Support: Pennine Care a Great Place to Work (GP2W).

Since 2006 the Trust has adopted an organisational development framework to ensure staff are supported, involved and engaged to ensure the Trust has the best workforce possible to deliver safe and effective care. It is a fundamental belief of the Trust that the best supported staff deliver the best services.

The strategy for Organisational Development (OD) has followed an Appreciative Inquiry approach and is underpinned by the principles of Emotional Intelligence and Mindfulness. However, as a Trust these theoretical models sit behind actual implementation and action to support staff. The following are key features of the Trust's approach to OD:

- launching a strategy and making a clear 'pledge' to support and engage staff and to act upon their views and values to make the Trust a great place to work;
- taking action on a 'You said, We did' approach across a range of initiatives;
- the development and implementation of a health and wellbeing strategy to support and promote physical and mental wellbeing in work;
- setting up and running a professional coaching service for staff;
- developing a leadership development programme which has now provided support to over a 150 senior and middle managers;
- setting up an Education Governance Group and a Learning and Development department to provide education and OD services;
- delivering clinical skills training programmes;
- driving up access to University based education;
- running OD events large and small to engage staff and communicate widely on Trust business and strategy;
- running professional engagement events;
- hosting Chairman and Chief Executive lunches; inviting a wide range of staff to meet the CEO and Chairman to discuss challenges and celebrate success;
- celebrating success with a series of Trust awards and events to recognise outstanding contributions to patient care;
- being nominated and winning several nationally recognised awards.

These are just some notable examples of OD in Pennine Care NHS Foundation Trust. Importantly it is a core principle by which the Trust runs its NHS business; that the most effective outcomes are achieved through the close involvement of the workforce in developing strategy and delivering change. The best ideas and successes in Pennine Care NHS Foundation Trust have been generated by the clinical staff who are closest to the patient care pathway.

New Ways of Working

New Ways of Working has been adopted across the North Division which was facilitated by the adoption of the inpatient consultant and community consultant roles. This has led to a much more responsive model of care where tasks are delineated across the multi-disciplinary team and are reviewed on a daily basis. Individual members of the multidisciplinary team are

held to account for their contribution at these daily meetings. This has replaced the traditional model whereby several consultants would each have a weekly ward round and hence decisions about patient care would predominately take place at that meeting. The result of this has been the adoption of a lean and high quality care pathway through the inpatient wards characterised by a true multidisciplinary approach to the development and ongoing evolution of the inpatient environment with meaningful patient and carer involvement.

12.1.15.3. Conclusions

Pennine Care NHS Foundation Trust has well-developed systems of clinical governance which facilitate performance management. The Independent Investigation Team whilst acknowledging that the Trust is still embedding their arrangements observed that there was substantial evidence to demonstrate that the system, at the time of writing this report, was working well. There was evidence to suggest strongly that clinical staff within the Trust understood clinical governance systems and performance management data. This was evident when examining the current functioning of Hollingworth Ward. This area has been identified as one of notable practice.

The things that caused Mr. Z's case to be managed poorly were not the 'big' things but the 'small' things. The basic building blocks of care. These basic building blocks often fall 'sub-audit' and as such it can be difficult to detect when they are absent or not being implemented. This is a lesson for every NHS Trust. Audit programmes will pick up issues that are covered within policies and procedures. However basic building blocks of care such as the taking of a psychiatric history and the building of a therapeutic relationships are considered so elementary that they are seldom included in clinical guidance and protocols. Consequently when practice falls short these issues remain undetected and patient care is compromised.

It must be remembered that no matter how sophisticated a clinical governance system may be, it needs to be sensitive enough to assure the most simple aspects of the delivery of care and treatment. These basic building blocks of care form the foundation upon which services are provided.

12.2. The Care and Treatment of Ms. X

The Independent Investigation Team interviewed Ms. X's Consultant Psychiatrist and several of the ward nursing staff who knew her well. The Team also conducted a review of Ms. X's case notes and subjected them to an analysis in order to determine whether any aspects of the care and treatment she received could have been viewed as contributing to her death. Ms. X received her care and treatment whilst on Hollingworth Ward from a different medical team to that of Mr. Z.

The Independent Investigation Team found no causal or contributory factors regarding the care and treatment that Ms. X received and her death at the hands of Mr. Z. This Investigation was asked to examine Ms. X's care and treatment, and this has been achieved. However the details regarding Ms. X have not been set out in an extensive manner as this is not required to understand the case. Out of consideration to the family and friends of the deceased, who whilst they have not been identified to date may read this report at a later time, a relatively non intrusive approach has been taken to the handling of her personal information. A simple psychiatric history has been given together with a chronology of her time on Hollingworth Ward during her last admission and up until the time of her death.

12.2.1. Background

Ms. X moved to England from Northern Ireland when she was 16 years old. She reported having had an unhappy childhood that was spent in both a childrens' home and a locked facility. Ms. X had never married or had children and she had lost touch with her parents and siblings at a young age.

Ms. X was often reluctant to talk about her past but did disclose that she had spent two and a half years in prison for assault and had a history of involvement with the Police due to her aggressive behaviour.

Ms. X was a single lady who was 59 years old at the time of her death. Ms. X had a relatively complex presentation in that she had a history of alcohol dependency (although she had been abstinent for a period of some fifteen years at the time of her last admission to Hollingworth Ward), a Personality Disorder with psychotic traits, and a late onset psychosis which was

thought to have been caused by her previous habit of abusing alcohol. Ms. X also suffered from recurrent depression.[125] Ms. X was a small-framed person who was about four feet and eleven inches in height and weighed about six and a half stones. She suffered from a number of physical conditions which included; osteoporosis, angina, heart valve defects, hypertension and epilepsy.

Over the years Ms. X would often become tearful and paranoid and would require urgent assessment which on occasion would require inpatient admission. At the time of her last admission on the 12 June 2007 she was living in supported accommodation and was struggling to cope. At the time of her admission in the summer of 2007 her Care Coordinator was seeking a residential placement for her. Ms. X had a dog called Lucky who was her constant and much-loved companion. It was understood that Ms. X could suffer severe relapses and at such times she could self harm and attempt suicide.

12.2.2. Psychiatric Care and Treatment on Hollingworth Ward between the 12 June and the 13 August 2007

12 June 2007. Ms. X telephoned her Care Coordinator. She stated that she was suicidal and *"felt like killing her dog."* [126] Ms. X was also experiencing command hallucinations, telling her to harm others, and visual hallucinations which took the form of her 'seeing' snakes coming out of the wall.[127] Ms. X was assessed by the On Call Senior House Officer accompanied by her Care Coordinator, they were joined by her Consultant Psychiatrist who offered an inpatient admission, which she accepted gratefully. The decision was taken to admit Ms. X on an informal basis to Hollingworth Ward. The impression recorded in the clinical records was that of a diagnosis of Paranoid Schizophrenia.[128]

On her arrival Ms. X received a comprehensive assessment which incorporated a risk assessment. She was described as being friendly and argumentative in turn and the decision was taken to place her on general observations. However following another assessment by the Senior House Officer it was agreed that Ms. X required 15 minutes observations due to the fragility of her physical health. It was also noted that Ms. X was a risk to herself, in that she

125 Medical Case Notes P 82
126 Medical Case Notes P 19
127 Inpatient Notes P 1
128 Inpatient Notes P 6

was expressing suicidal ideas, and also a risk to others, in that she was capable of being violent and aggressive.

Between the 13-20 June 2007. Ms. X settled onto the ward. She was reported as missing her dog and was observed to be tearful on occasion. During this period whilst still hearing voices, which upset her, Ms. X was not aggressive and became gradually brighter in mood.

21 June 2007. On this day Ms. X became physically unwell. She reported central chest pain and light headiness. She was escorted to bed and her physical observations were taken. Ms. X was unable to maintain her breathing without oxygen and the On Call Doctor was called. A 444 call was made and a Senior House Officer assessed Ms. X whilst she awaited transfer to the Accident and Emergency Department at the Rochdale Infirmary. Once Ms. X had been assessed at the Accident and Emergency Department a call was made to the ward to advise them that Ms. X was prescribed oxygen for breathlessness and that she normally had access to this at her home. Following a course of oxygen therapy Ms. X was returned to Hollingworth Ward.[129]

22-24 June 2007. During this period Ms. X was recorded as being bright in mood. On the 24 June she became short of breath once again and this time responded well to oxygen therapy on the ward.[130]

25 June 2007. A ward round was held at which Ms. X presented as tearful and expressed ideas of self loathing and worthlessness. She still had some suicidal thoughts, but had no active plans to harm herself. Following the ward round Ms. X was observed by nursing staff to be settled.[131]

26-30 June 2007. During this period Ms. X made two short home visits. She was recorded as being brighter in mood, but continued to experience shortness of breath.

1-4 July 2007. Ms. X continued to be well. On occasion she would have altercations with staff, but only of a minor nature. On the 3 July Ms. X went on overnight leave to her home,

129 Inpatient Notes P 34
130 Inpatient Notes P 35
131 Inpatient Notes PP 36-37

returning back to the ward for her medication. It would appear that Ms. X had a *"bad leave"* as she found it difficult to sleep.[132]

5-9 July 2007. During this period Ms. X was unsettled and argumentative. On the 5 July she experienced severe difficulties with her breathing. She became cyanosed and was taken by 999 ambulance to Rochdale Infirmary at 6.00 hours. Ms. X returned back to the ward in the early afternoon when she wanted to leave the ward to smoke a cigarette. Nursing staff tried to dissuade her and Ms. X became abusive and *"lunged"* at a nurse who grasped her forearms in self defence. Following this it became apparent that Ms. X had hurt her arm.[133]

The following day Ms. X was taken to Rochdale Infirmary where she was treated for a broken arm. On her return to the ward Ms. X was seen to be clutching at her chest and was heard to be complaining of sharp chest pain. A 444 call was made and an ambulance requested for a cardiac arrest. However on the arrival of the ambulance Ms. X appeared a little better and refused to be taken to hospital.[134]

Until the 9 July Ms. X was periodically aggressive and unsettled.

10-26 July 2007. Ms. X continued with a fairly settled pattern of behaviour. She was generally bright with no reported hallucinations and her behaviour was appropriate.

27-31 July 2007. Once again Ms. X was reported as being settled. During this period she had experienced one episode of visual hallucinations that had upset her, and she also experienced one episode when she was short of breath.

1-4 August 2007. Ms. X spent time both at her home and on the ward. On the 4 August she reported that she thought the other patients were saying nasty things about her.[135]

5-13 August 2007. Ms. X continued as before. She was generally bright and settled. On occasion she expressed paranoid ideas about the other patients on the ward but nothing of

132 Inpatient Notes PP 40-42
133 Inpatient Notes PP 43-44
134 Inpatient Notes P.35
135 Inpatient Notes P 69

significance was recorded. No mention was made in the notes of her having specific difficulties with any of the patients on the ward.

At 17.20 hours on the 13 August 2007 Ms. X was found collapsed in the female lounge on the ward. On this occasion it would appear that a 999 call was made instead of the usual 444 emergency assistance call. ***At no time during her stay on the ward could the staff recall her ever having had any interaction of any kind with Mr. Z prior to the incident occurring.***

Care Programme Approach

Assessment

In November 2006 Ms. X was transferred from 'Standard' CPA to 'Enhanced' CPA and at this stage was transferred to a Community Mental Health Team (CMHT) and allocated a Care Coordinator within the CMHT. This referral was made by her General Practitioner. Between this time and her death on the 13 August 2007 assessment of both Ms. X's needs and risk were undertaken on a regular basis in a comprehensive and appropriate manner.

Care Planning

On examination of Ms. X's clinical records care planning was found to be of a detailed, dynamic and holistic nature. It was evident that the decline in Ms. X's social functioning was understood and monitored appropriately. There was evidence that the Care Coordinator acted in a proactive manner to ensure that Ms. X could be found a suitable residential placement as her social functioning mental health condition began to decline.

Care Coordination

The Care Coordinator worked with the care network (Consultant Psychiatrist, General Practitioner etc.) to ensure that everyone was kept informed with regard to Ms. X's mental health and social care needs. The clinical documentation was kept up-to-date. Letters and care plans demonstrated that a high degree of liaison took place between different agencies and services.

Documentation and Professional Communication

This was found to be of a good standard between November 2006 and 13 August 2007. There was evidence to show that professionals communicated on a regular basis one with the other

and that care planning was a multidisciplinary team function. This was of particular note with regard to the relapse and crisis plans developed for Ms. X which were of a high standard.

Summoning 444 Emergency Assistance

It was evident that Ms. X suffered from very poor health and that she had collapsed on several occasions prior to her eventual death on the 13 August 2007. On each of the previous occasions a combination of 999 and 444 emergency calls were deployed in order to summon emergency assistance. The 444 process was the agreed process for summoning emergency assistance on the Birch Hill site in the event of a suspected cardiac arrest. It was recorded in the clinical record that the 444 procedure had led to a timely response from the ambulance service. It remains unclear why on the 13 August a 999 ambulance was summoned instead of a 444 emergency request.

12.2.3. Conclusions

It was the conclusion of the Independent Investigation Team that there were no causal or contributory factors regarding the care and treatment that Ms. X received and her death at the hands of Mr. Z.

The Care Programme Approach and accompanying risk assessments appear to have been implemented in an appropriate manner in the case of Ms. X, whilst she was in both community and inpatient settings. Her Care Coordination appears to have been able to deliver CPA which was both comprehensive and effective over time in that it was able to maintain Ms. X in the community, whilst also ensuring that she was managed appropriately when her health broke down and required inpatient intervention. Ms. X had well-developed care plans which also detailed crisis and relapse plans that set out the roles and responsibilities of each clinician within the care network.

During her stay on Hollingworth Ward her vulnerability, both physical and psychiatric, was recognised and managed appropriately.

It was evident that Ms. X was a physically frail individual who had experienced significant health problems during the weeks that led to her death. Her physical fragility and health problems were managed with a high degree of competence by the Hollingworth Ward staff. It

would not have required a forceful act of violence to have caused Ms. X either significant or fatal harm.

The Independent Investigation Team concluded that the care and treatment Ms. X received was of a satisfactory standard which was appropriately tailored to her particular health and social care needs, and that no act or omission on the part of the clinical team with regard to *her* care and treatment placed her in a position of risk.

13. Findings and Conclusions Regarding the Care and Treatment Mr. Z Received

13.1. Findings

The findings have been identified following a full review of the care and treatment that Mr. Z received from the Pennine Care NHS Foundation Trust. These have been set out below together with their accompanying relevant causal, contributory and service issues.

1. **Ward Environment.** There were two points of significance here. First: the ward environment at the time of the incident was far from ideal, however the Internal Review report addressed many of these issues. The Independent Investigation Team felt that the ward environment could be further improved by making changes to the functionality of the ward. Second: there were outstanding issues regarding the delivery of services on a small site. These potentially affect the integrity of the service offered. Issues of concern were identified as currently including:

- clinical supervision and access to expert/professional advice;
- medical, psychiatric and environmental emergencies, (especially at night);
- staff training and access to library services;
- reduced multidisciplinary team provision;
- fewer opportunities for normalisation/implementation of the recovery model utilising community-based resources (e.g. maintaining networks and community-based support, being able to use community-based facilities).

- ***Contributory Factor Number 1 (Influencing). Environmental factors came together on the 13 August 2007 in such a way that they contributed to the attack on Ms. X occurring and also going undetected.***

2. **Diagnosis.** Mr. Z was diagnosed with depression with psychotic features. This was a reasonable diagnosis to make. However *"?PTSD"* (Post Traumatic Stress Syndrome) also appeared in the clinical record. If this condition was present then it would have exacerbated any erratic behaviour Mr. Z presented with. The potential presence of PTSD was not examined. The notion that Mr. Z had PTSD is an important one given his history and psychotic presentation. His distress was a significant part of his

presentation and the impulsivity that could be expected from a person with a possible PTSD was not taken into account.

- ***Contributory Factor Number 2 (Influencing). The failure to assess Mr. Z within the context of his personal history and presenting symptomology led to a delay in providing him with an appropriate care and treatment plan. Delayed and inappropriate assessment also ensured that his condition was not considered in the full light of everything that was known about him at the point of his admission to the ward.***

3. **Medication and Treatment.** Mr. Z was admitted onto the ward with a diagnosis of depression with psychotic features. It was decided to assess Mr. Z drug free for 48 hours. Although, it is good practice for new admissions to psychiatric wards to have periods of assessment without treatment for the purpose of diagnosis, there was no justification for not providing the patient with *'pro re nata' (*prn) medication to help him with his anxiety, distress, fear and insomnia. Mr. Z was admitted on 1 August after presenting with psychotic symptoms. Mr. Z actually went six days without medication. He was given antidepressant medication, Citalopram, six days after admission. He was not given any antipsychotic medication until 9 August, eight days after his admission. Nursing staff had to resort to calling in the duty doctor in order to manage Mr. Z's considerable distress which continued throughout his inpatient stay. Drug-free assessments have to be well structured with teams knowing what is to be assessed and how this is to be achieved.

- ***Contributory Factor Number 3 (Influencing). The care and treatment plan offered to Mr. Z was not based upon a comprehensive or coherent assessment process. Consequently it was not possible to understand exactly what problems the clinical team were hoping to affect. The clinical team did not have a clear formulation of Mr. Z's problems and did not identify any clear goals for treatment. One may not expect depressive or psychotic symptoms to be abated in 13 days. However Mr. Z's anxiety, fear, agitation, restlessness, poor sleep and overall distress could have been managed more effectively.***

4. **Use of the Mental Health Act (1983).** This was found to have been used appropriately. However the ward did not follow its own policy and procedure regarding its process relating to informal patients.

- ***Service Issue Number 1. The Trust did not distinguish between the rights of informal and voluntary patients. Admission processes were not clear and would serve to potentially mislead both clinicians and patients alike.***

5. **Care Programme Approach (CPA).** No evidence exists to show that CPA had been commenced whilst Mr. Z was on Hollingworth Ward. Mr. Z was made homeless within a few days of being admitted and he would have required a high degree of input to be made ready for discharge. CPA provides for a holistic assessment and planning approach to be taken, it was not clear how this would have been managed for Mr. Z.

- ***Contributory Factor Number 4 (Influencing). The failure to provide CPA to Mr. Z meant that he did not receive a comprehensive and holistic assessment. This in turn ensured that he was never understood fully in the context of his personal history, social care needs and cultural background. This contributed to the failure to provide Mr. Z with the interventions and support that he needed.***

6. **Risk/Clinical Assessment.** There was no record of either informal or formal risk assessment being carried out by the treating Medical Team. There was also no record of any proper/thorough history taking and Mental State Examination being carried out by the medical members of the treating team. The Named Nurse conducted a sound assessment on the 1 August 2007, however there was no indication that the Medical Team benefited from this. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time. Hamilton rating scales were used on Mr. Z when the team were still uncertain whether or not he could understand English. The scale was rendered unreliable as a psychometric tool for use with Mr. Z because of his cultural background and potential linguistic limitations.

- ***Contributory Factor Number 5 (Influencing). Mr. Z was not assessed within the context of a comprehensive and dynamic risk assessment process. This ensured that***

Mr. Z was not understood within the context of his presenting symptomology and no appropriate management plan was either developed or implemented.

7. **Referral, Admission and Handover Processes.** This appears to have been conducted in a competent manner.

8. **Cultural Diversity and the Care of Asylum Seekers.** Trust clinicians did not take into account the significant cultural diversity issues raised when providing care and treatment for individuals such as Mr. Z. Neither was best practice guidance considered when providing care and treatment for a person who was an asylum seeker.

- ***Contributory Factor Number 6 (Influencing). Mr. Z was not assessed and treated within the context of his personal history and cultural background. His vulnerabilities as an asylum seeker with emergent mental health problems were not understood and Mr. Z was assessed in a culturally inappropriate manner that failed to identify his care and treatment needs.***

9. **Service User Involvement in Care Planning and Treatment.** There was a degree of uncertainty within the treating clinical team whether or not Mr. Z could understand English. This factor was given as a reason why his assessment had not been undertaken in the usual way. Mr. Z was an asylum seeker who had experienced a traumatic sequence of life events. These were not taken into account in an appropriate manner. Throughout Mr. Z's time on Hollingworth Ward minimal effort appears to have been made to engage him in his care and treatment and to build up a therapeutic relationship with him. Had more time been spent with him it would have become apparent that Mr. Z had a competent understanding of the English language and that this did not present a barrier to communication.

- ***Contributory Factor Number 7 (Influencing). Mr. Z did not receive the kind of patient-centred care that would have aided either his short-term care and treatment or long-term recovery. This served to exacerbate his isolation and ensured that he remained an unknown quantity to the clinical team.***

10. **Documentation and Professional Communication.** Medical inputs in this area were deemed to be poor. Doctors did not write comprehensive notes in the clinical record, and neither did they routinely read through clinical records prior to ward rounds. There was an assumption that Mr. Z was admitted onto the ward with little information about him being known, this was not correct. There was reliance by doctors on nursing staff to conduct assessments and a culture of not recording what was discussed. Doctors felt that had they known more about Mr. Z they would have acted differently, this information was available to them, but remained unread and was not taken into account. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time.

- ***Contributory Factor Number 8 (Influencing). The decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Clinical Team at the time. As a result Mr. Z did not receive the care and treatment that he required.***

11. **Overall Clinical Management of the Case.** There did not appear to have been multidisciplinary team working on the ward in any meaningful sense. Nursing and medical assessment and care and treatment planning appear to have been conducted separately with no process in place to bring them together. The ward round did not benefit from a proper multidisciplinary input with the Named Nurse main function appearing to be that of patient escort. This situation was exacerbated by the lack of an integrated clinical record. As a consequence Medical Staff did not read the nursing notes and in effect based care and treatment decisions on their own observations only. Decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Medical Team at the time. After a 12 day period on the ward Mr. Z was still not in receipt of an appropriate care and treatment plan based on a sound multidisciplinary assessment.

- ***Contributory Factor Number 9 (Causal). The level of care and treatment that Mr. Z could reasonably have been expected to receive was not delivered. Risk management and evidence-based care and treatment can reasonably be expected to improve mental health and reduce risk. This factor was under the direct control of the clinical team and therefore the team retained a high degree of influence over***

the mental health of Mr. Z and thereby the circumstances that led to the killing of Ms. X.

12. **Resuscitation Process.** The resuscitation process, on the whole, was managed well. The main point of learning was in the summoning of the ambulance. This did not work smoothly with the ambulance call centre being given the details for a 'green' alert (non-urgent) rather than for a 'purple' alert (urgent). The ensuing delay was due to this factor. There was also a degree of confusion regarding 999 and 444 procedures for summoning emergency support.

- ***Service Issue Number Two. An inherent system failure was identified as the result of the Independent Investigation regarding the procedure required to call an ambulance for assistance to emergency situations. It was evident that there was confusion with regard to the emergency call out system in that a combination of 999 and 444 procedures were interchangeably used.***

13. **Clinical Supervision.** Supervision did not happen on a regular basis. However this did not directly affect the outcome of the case.

- ***Service Issue Number Three. Poor clinical supervision practice was evident on Hollingworth Ward at the time Mr. Z received his care and treatment.***

14. **Adherence to Local and National Policy and Procedure, and Clinical Guidelines.** The clinical team did not adhere fully to policy and procedure. This was a particular issue with the medical staff. This was particularly noticeable in the areas of:

- risk assessment;
- record keeping;
- national Post Traumatic Stress Disorder Guidelines;
- asylum seeker clinical management.

- ***Contributory Factor 10 (Influencing). The Trust policies and procedures were found to be of an excellent quality, however adherence to them was found to be poor with regard to clinical record keeping and clinical assessment (including risk***

assessment). National best practice guidelines pertinent to the management of Mr. Z were not followed.

15. **Organisational Change.** The care and treatment that Mr. Z received was given in the context of ongoing organisational change. This change in itself did not affect clinical practice in a negative manner. However clinical record systems and multidisciplinary working have been identified by the Independent Investigation Team as requiring significant redesign and this is currently being addressed as part of the Trust's ongoing organisational change strategy.

16. **Clinical Governance and Performance**. Several issues were noted that would indicate clinical governance failed to operate coherently on the unit at the time of the incident. This was evidenced by the lack of integrated records, multidisciplinary team working and the failure to provide the basic building blocks of care, e.g. assessment, psychiatric history, implementation of care plans, teaching and training etc. The Trust audit cycle may not have been robust enough to detect shortfalls in practice. However in 2010/2011 it was found that clinical governance practices were of a notable practice standard.

17. **The Care and Treatment of Ms. X.** The Independent Investigation Team found that the care and treatment of Ms. X was appropriate and did not contribute in any way to her death.

18. **Internal Review.** The internal review was competently prepared. However it is not unusual for an independent process with a wider-ranging set of terms of reference to make additional findings, as was the case with this Independent Investigation.

13.2. Conclusions

It was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Z and his untreated and deteriorating mental state. When examining the effectiveness of care and treatment it is reasonable to assume the following:

- sound assessment leads to a) a plan to manage risk, care and treatment b) informed care and treatment;

- risk management and treatment plans can reasonably be expected to reduce risk and to improve mental health.

His Honour Judge Gilbert Queen's Counsel on sentencing Mr. Z said *"in a modern society those who suffer from the affliction of mental illness or disorder must be treated with the same sympathy and care as attends those suffering from any other illness…I am satisfied on the evidence that you were suffering from paranoid schizophrenia in a particularly severe form. It led you to kill your victim"*.[136] This Investigation found a direct causal link between the care and treatment that Mr. Z received and his untreated and deteriorating mental state. The sentencing Judge made the causal link between his mental state and the death of Ms. X.

However, despite the above finding, it was also the conclusion of the Independent Investigation Team that the Pennine Care NHS Foundation Trust in 2011 is the provider of sound mental health services and that this case probably represented a rare occurrence in the life of the Trust, and that both commissioners, and the local population should have every confidence in the services provided.

When examining the quality of the care and treatment a person receives from a mental health Trust the following four findings categories can be utilised when causality is being considered.

Category 1. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice and the Independent Investigation Team was unable to identify any causal or contributory factors to the homicide in question.

Category 2. The Trust implemented high standards of service delivery that were appropriate, effective and in keeping with best practice. However a single act or omission, or the unexplained practice of a single team, led directly to the circumstance in which a serious untoward incident occurred. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

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Category 3. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. However no direct causal relationship between what the services actually did or did not do was connected to the incident.

Category 4. The Trust delivered less than effective services where systems were chaotic and best practice standards were not implemented. Causality was found between the untreated mental state of the service user/the quality of the care and treatment provided, and the subsequent actions of the service user.

It was the conclusion of the Independent Investigation Team that the Pennine Care NHS Foundation Trust findings belonged to Category 2. It was evident that there was a direct causal link between the omissions of the clinical team providing care and treatment to Mr. Z, his untreated mental state, and the death of Ms. X. However it was also the conclusion of the Independent Investigation Team that the Pennine Care NHS Foundation Trust in 2011 is a sound provider of mental health services and that this case probably represented a rare occurrence in the life of the Trust and that both commissioners and the local population should have every confidence in the services provided.

The case of Mr. Z was not managed well and as a result he was not understood in the context of the risk that he presented. Neither did he receive the care and treatment that his condition required. Causality was found on the part of the Trust because Mr. Z killed Ms. X as a direct result of his inappropriately assessed, and treated, mental state. In a situation of this kind it has to be determined whether the circumstances surrounding an incident were under the control of the Trust or not. In this case Trust personnel did not act appropriately based upon what they knew. They had within their control a high degree of determination over the situation and assertive action on their part would have impacted positively on Mr. Z's mental health and the management of the risk that he presented both to himself and to others. Mr. Z's presentation was such that a serious untoward incident of some kind was definitely foreseeable. Had the necessary actions by his clinical team been put into place a serious untoward incident of the kind that did take place would probably have been preventable.

Any conclusions based on the examination of a single episode of care that totalled thirteen days need to be qualified. Whilst some aspects of the care and treatment Mr. Z received were assessed to be poor, it has to be recognised that Ms. X was found to have received a very

appropriate and effective care and treatment package on the same ward at the same time. No sweeping generalisations can be made about how services were delivered on the Birch Hill site when seen through the lens of Mr. Z's care and treatment in isolation.

Mr. Z's case brought together an unusual set of circumstances. These circumstances were of the kind that Mr. Z's clinical team had not seen before and were ill equipped to deal with. Mr. Z's case was very much a test for the clinical team in the management and delivery of what would normally be required to ensure a truly patient-centred approach. This lay at the heart of Mr. Z's case. Mr. Z was never understood in the context of his culture, his history or his mental state. Limited attempts were made to engage with him and to build up a therapeutic relationship with him. The need to engage with Mr. Z and to build up a therapeutic relationship with him had been identified by the nursing team as being part of his care plan. However for whatever reason it was not implemented.

The things that caused Mr. Z's case to be managed poorly were not the 'big' things but the 'small' things. The basic building blocks of care. These basic building blocks often fall 'sub-audit' and as such it can be difficult to detect when they are absent or not being implemented. This is a lesson for every NHS Trust. Audit programmes will pick up issues that are covered within policies and procedures. However basic building blocks of care such as the taking of a psychiatric history and the building of a therapeutic relationships are considered so elementary that they are seldom included in clinical guidance and protocols. Consequently when practice falls short these issues remain undetected and patient care is compromised.

14. Pennine Care NHS Foundation Trust Response to the Incident and Internal Review

The Trust worked together with the Police Service and the Health and Safety Executive in accordance with the Joint Agency Memorandum of Understanding (2006). The Memorandum sets out the process for multi-agency working on the occasion when each agency has to conduct investigations and inquiries concurrently.

14.1. The Trust Serious Untoward Incident Process

In accordance with extant Trust policy at the time of the death of Ms. X the Trust Board commissioned an internal review of the serious untoward incident. Prior to this time the Pennine Care NHS Foundation Trust had not experienced a death of this kind for many years. Due to this fact, and coupled with the serious nature of the incident, it was decided to commission two external consultants to be members of the review team who could provide both an independent degree of rigour and the level of experience that was required in order to ensure a robust investigation took place.

Initial Reporting of the Incident

Following the death of Ms. X and the arrest of Mr. Z the incident was reported to NHS North West and NHS Heywood, Middleton and Rochdale with immediate effect. A Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) notification was sent to the Health and Safety Executive. On the 5 September 2007 a Joint Agency Meeting took place with membership drawn from the Greater Manchester Police Force, the Health and Safety Executive and the Pennine Care NHS Foundation Trust. This meeting worked in the spirit of the Memorandum of Understanding (2005) that sets out best practice guidance for the management of incidents that require NHS, Police and Health and Safety Executive investigations to run concurrently.

The 72 Hour Report

This report was completed by the Locality Manager. The report was comprehensive and was written after discussing events fully with the team members involved with the incident. At the time the report was written no causes for immediate concern were identified that required

urgent action to be taken in order to ensure the continued safety of the patients on Hollingworth Ward.

14.2. The Trust Internal Review

The Internal Investigation Review Team comprised the following personnel:

- an independent investigation Chair;
- an independent investigator;
- the Trust Medical Director;
- a Trust Non Executive Director.

The Terms of Reference

The Terms of Reference were agreed by the Pennine Care NHS Foundation Trust Board. They were as follows:

"The purpose of the review is to thoroughly and objectively, examine the care and treatment of both patients in order to identify any shortfalls, establish the lessons to be learned to minimise the possibility of similar events and to make recommendations for the delivery of Mental Health Services in the future.

The review will examine the serious untoward incident (SUI) by applying a root cause analysis process, scrutinising the written evidence and interviewing key individuals.

The review will specifically examine the circumstances surrounding the care, treatment and compliance of both patients, in particular the history, quality, nature, scope and monitoring of their health, social and community care and risk assessment.

A report will be prepared, detailing the chronology of events, comprehensively scoping the incident and providing clear conclusions and recommendations.

This will be achieved by:

1. *Reviewing clinical records of both patients and commenting on the appropriateness of their assessment, care and treatment.*

2. *Appraising the adequacy of the risk assessment and management plan undertaken by the multidisciplinary team, with particular reference to the policy of the Trust and best practice. Also, the competencies and supervision and the relevant efficacy of collaboration between agencies.*
3. *Examining the adequacy of systems, operational policies, procedures, communication, partner working and governance arrangements.*
4. *Specifically reviewing the environment, diversity and privacy and dignity issues.*
5. *Examining best practice from any previous relevant complaints and serious untoward incidents (SUIs) over the last twelve months, any gender issues, to make comparisons and action plans, together with reports of Mental Health Act Commission visits and relevant complaints.*
6. *Assessing any family carer involvement.*
7. *Consider any workforce, Human Resource, training and supervision issues in relation to staff.*
8. *Considering any other matters relating to the public interest.*[137]

Methodology

During the course of the internal investigation the Review Team interviewed formally twenty witnesses from the Trust. The Review Team also obtained written statements and information from nine other witnesses external to the Trust. These individuals included: the GPs of both Mr. Z and Ms. X, the Staff Grade Doctor from Rochdale Infirmary who saw Mr. Z on the 1 August 2007, a Project Worker from Leopold Court, a member of the Greater Manchester Police Force, and Mr. Z's Consultant Forensic Psychiatrist at Ashworth Hospital.

The Review Team considered a comprehensive set of documentary evidence which included the clinical records of both Mr. Z and Ms. X, relevant Trust clinical policies and Trust clinical governance reports, procedures, Board minutes and action plans. The Review Team also set their work within a robust secondary literature context.

To support their investigation the Review Team ran a Root Cause Analysis half day workshop on the 5 December 2007 with individuals who were involved in the care and treatment of Mr. Z and Ms. X. The aims and objectives of the workshop were to:

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- *identify any gaps in the evidence obtained so far;*
- *agree how such gaps can be filled;*
- *clarify any inaccuracies or misperceptions;*
- *eliminate any hindsight or outcome bias;*
- *enhance the understanding of what occurred and why;*
- *refine the findings/themes;*
- *outline recommendations for any remedial action.*[138]

Key Findings

The internal review set the findings down under the National Patient Safety Agency Root Cause Analysis Headings.

1. *Patient/Individual Factors*

Little was known about Mr. Z's health prior to his being admitted to Hollingworth Ward on the 1 August 2007. It was known that Mr. Z had received asylum seeker status and had reported a history of both imprisonment and torture. On admission it was evident that Mr. Z was distressed and paranoid, he grew worse over the 13 day period he was on the ward. There was no evidence that adjustments were made to his care plan or risk assessment in the face of his deteriorating condition.

2. *Communication Factors*

- It was unclear when the Accident and Emergency medical notes arrived onto the ward. The Doctor who assessed Mr. Z in Accident and Emergency did come onto the ward on the evening of his admission and had a discussion with the ward staff. There was no recollection that Mr. Z's threat to kill himself or others was communicated at this stage.
- The ward nursing handover time of 15 minutes was thought to be too short.
- The STAR risk assessment tool was not filled in by the Multidisciplinary Team. Instead it was filled in predominantly by the nursing staff.

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3. *Working Condition Factors*

- The ward environment was not purpose built for mental health patients and observation was difficult. The staff had not been involved with consultation processes regarding the refurbishment of the ward and they inherited a clinical environment that was difficult to work in.
- The female-only area was relatively isolated and the female lounge bordered on a mixed male/female bedroom area.
- The ward alarm system was not adequate in that it could not be heard in all parts of the ward.
- No additional funding was allocated by the Primary Care Trust for the identified increased staffing levels following the refurbishment of the environment and development of the service.
- There was limited investment in other professional groups such as Occupational Therapy and Psychology services.

4. *Education and Training Factors*

- Clinical supervision was not accessed by most of the staff for a variety of reasons including a lack of supervisors.
- Nursing staff were concerned about their lack of knowledge of cultural diversity issues particularly in relation to the issues of those who seek asylum.
- Whilst most staff had received training in basic life support some bank staff had not received this training.
- Induction for temporary and bank staff was not consistently provided.

5. *Team and Social Factors*

- It was felt by the nursing staff that the psychiatrists did not see patients often enough and that changes to care and treatment plans made in ward rounds (weekly) were not followed up quickly enough if problems occurred.
- The nursing team worked well together.
- The relationship between medical and nursing assessments was not clear. It was felt that the medical staff could be more engaged in the management of the service and provide a clinical perspective to support management decisions.

6. *Task Factors*

- The observation policy was not adhered to in that Mr. Z did not have an observation care plan.
- The nurses who took part in the resuscitation found using the suction machine difficult.
- The standard of clinical risk assessment was good in part, however the risk Mr. Z posed to others was not identified and the implications not addressed.

7. *Organisational/Strategic Factors*

- There was an increasingly high number of patients being admitted to Hollingworth Ward whose histories were unknown.
- The ambulance response was delayed because the satellite navigation system picked the wrong post code.
- The clinical interventions Mr. Z received were not recorded in an integrated manner and changes to condition, care and treatment were not necessarily linked together.

8. *Findings specific to Ms. X*

Ms. X had been in hospital nine weeks prior to the incident. She presented with a mixed picture on the day of the incident, she appeared to be settled but reported a number of psychotic symptoms. Ms. X often was labile in mood and would often present according to the situation she found herself in and the people that she was speaking to. There was no indication that Ms. X's behaviour was putting her at risk on the ward on the day she met her death.

Internal Review Team Analysis and Conclusions

- Mr. Z was suffering from a paranoid condition. However Mr. Z appeared to be gentle and timid in his presentation with no signs of verbal or physical aggression.
- The Internal Review Team commended the ward use of the Monty-Asberg and Hamilton Depression Rating Scales.
- The incident brought a unique set of circumstances together in that two vulnerable individuals were brought together within the same ward context, and was compounded by the physical frailty of Ms. X.

- The ward environment whilst not ideal, did not contribute in any degree that blame for Ms. X's death could be attributed to it.
- A lack of integrated care and treatment took place in the case of Mr. Z. Risk assessment and formulation did not occur in a cohesive way.
- Whilst there were some clear deficits in the environment, some concerns with the system and aspects of the organisation, and the occasional misjudgements, the Internal Review Team did not feel that they were to any such degree that blame for Ms. X's death could be attributed to the service or any clinicians involved. The Review Team consider that Ms. X's death was not foreseeable or preventable.

Internal Review Team Positive Factors Identified

- Initial care planning documentation for Mr. Z was of a high standard.
- All staff had received recent basic life support training.
- The staff involved in the incident responded quickly and efficiently including managing the other patients and the immediate aftermath.
- The response to the incident from the staff on the Moorside Ward was very good and supportive demonstrating good team working between the two wards.
- The managers of the service responded to the incident very quickly providing direction and leadership. In addition the Executive and Senior Managers attended the ward the same evening talking to staff and patients and providing support.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

Process

A comprehensive review archive was created which was made available to the Independent Investigation Team. The Independent Investigation Team found the internal review was managed in a robust and competent manner in accordance with both local and national best practice guidance.

The Independent Investigation Team were impressed with the methodology that the internal review adopted. The primary and secondary literature review that was undertaken was both appropriate and thorough. The chronology and timeline were accurate and used to formulate

themes and to identify interview questions appropriately. The internal review archive provides an illuminating account of the meticulous investigative process that was followed.

Findings and Conclusions

Whilst the Independent Investigation Team agree that Ms. X's death could not have been foreseen, sufficient information was held about Mr. Z which should have given rise to a more robust care and treatment plan. At the time of Mr. Z's admission it was known that he was:

- an asylum seeker and had been imprisoned and tortured;
- *"PTSD?"* appeared in the clinical notes;
- medical staff did not read all of the clinical information in their possession and did not make care and treatment decisions based on everything that was known about Mr. Z at the time;
- Mr. Z's distress and paranoia continued to escalate but was not proactively treated;
- Mr. Z should not have had the Monty-Asberg and Hamilton Depression Rating Scales used as they were not validated for use on a person with his ethnic background;

The Independent Investigation Team found that had the clinical team providing the care and treatment for Mr. Z acted upon all of the information that was known to them, and should have been known to them, then his psychiatric condition could have been more successfully treated and the circumstances that led to the death Ms. X may have been prevented. This differs from the conclusion drawn by the Internal Review Team.

The Independent Investigation Team also made a different finding with regard to the delay of the Ambulance Service when arriving at the scene of the incident. After meeting with the Ambulance Service and reviewing the log created contemporaneously at the time of the incident it transpired that the 'delay' was due to the fact that the original call from Hollingworth Ward did not state the incident was to be dealt with as an emergency.

Differences in findings and conclusions between internal and independent teams are not uncommon. This does not necessarily mean that one team has reviewed the same information in a different way, or has managed to process things differently. The time interval between the initial internal review and the independent investigation ensures that witnesses have time to reflect and additional information is often brought forward. This was

the case when the Independent Team conducted its Investigation into the care and treatment that Mr. Z received from the Pennine Care NHS Foundation Trust.

One point of learning for the Pennine Care NHS Foundation Trust when managing future internal reviews would be to ensure that the Terms of Reference do not become compromised by turning a simple investigation process into a wide-scale service review. In the case of the internal review into the care and treatment of Mr. Z it was decided to widen out the investigation. Whilst the service improvement ethos behind this decision was commendable it served to delay the findings of the review for a period of some nine months. In future it would be better practice to undertake an internal investigation in accordance with national best practice guidance, and then if a wide-scale service review is deemed necessary to make this a recommendation of the Serious Untoward Investigation process. Trusts must not forget that the primary purpose of an internal review is to understand the learning in order to make services as safe as possible as quickly as possible (within 60 days of the incident) in order to prevent a similar event from occurring again. Any delays are to be avoided.

14.3. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress caused;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;

- receive a plan about what can be done medically to repair or redress the harm.

No friends or family members could be found for Ms. X. The Police conducted a comprehensive search and put out a series of media appeals but no one could be found. In this case the Trust *Being Open* Policy was not required.

Directly following the incident and during the course of the internal investigation contact could not be made with the family of Mr. Z as they could not be traced in Ethiopia. It was also decided, upon additional reflection, that contact with Mr. Z's family in Ethiopia may endanger them. In this case the Trust *Being Open* Policy could not be implemented.

14.4. Staff Support

Prior to, and During, the Internal Review

It was evident from reading the Trust internal review archive that the Hollingworth Ward staff were supported by senior managers both during the incident and directly after it. On the night of the incident The Trust Top Team, including the Chief Executive, came to the ward to offer support and to ensure that all appropriate management functions were initiated appropriately.

All of the witnesses interviewed by the Independent Investigation Team were able to articulate how much they appreciated the support that they received during this period. It must be noted that nursing staff witnesses were significantly traumatised by the incident as it happened in their workplace and they knew the deceased, Ms. X, well. The Trust worked with all witnesses in a sustained and supportive manner.

During the Independent Investigation

The Trust continued to provide support and practical assistance to all witnesses during the Independendent Investigation process. The Trust worked with the Independent Investigation Team to ensure that witnesses were prepared and supported throughout. This case has been difficult for witnesses on many levels. Many of them experienced a murder in their workplace, applied an appropriate and professional (but unfortunately unsuccessful)

resuscitation on a person that they knew well, and had to experience Police, Inquest, NHS and Health Safety Executive investigations and inquiries.

It is to the credit of both the witnesses and the Trust that individuals were able to provide reflective witness statements and were able to engage in the interview process in a professional and honest manner during the Independent Investigation process.

14.5. Trust Internal Review Recommendations

The following are the recommendations as they appear in the Trust Internal Review.

Referral and Admission

1. The Trust must review and standardise the process of transfer of initial assessment medical notes from Accident and Emergency to the admission ward. Best practice would suggest that the notes should go with the patient during transfer and arrive on the ward at the same time.
2. The Trust should review the means by which patients are transported safely from Accident and Emergency to the admission wards. This is in order to reduce the length of time patients spend in an inappropriate setting when they are particularly unwell and minimise the risk of harm to themselves or others.
3. The Trust needs to ensure that it addresses the issue of obtaining information concerning patients who are accessing the mental health services for the first time whose history is difficult to obtain, particularly in relation to people who are homeless and housed in Rochdale from other areas. There are three specific areas to address:
    - information sharing between external agencies who run hostels for the homeless;
    - partnership working with the Local Authority and Commissioners in relation to the impact of Rochdale's housing policy on service provision;
    - greater collaboration between secondary and primary care services and sharing of information.

Clinical Risk Assessment

4. The Trust should ensure that all clinical staff are sure of their roles and responsibilities regarding risk assessment including its documentation and daily use

for patient management and information sharing at handover, clinical review meetings and ward rounds.

5. The risk assessment should be regularly updated especially in rapidly developing situations e.g. at admission or when there is an inadequacy of background information or records detailing the clinical history which results in uncertainty and the patients' behaviours are unpredictable. In addition information on risk must be made available for staff who are unfamiliar with the patient.
6. Consideration should be given to the Trust's policy on risk assessment and management in relation to the reduction of the risk of self harm by the removal of items that can be potentially used for this purpose and how this issue should be managed in a clinical setting.

Care Planning and Delivery

7. The Trust should ensure that staff receive education and training, which is regularly updated, in relation to the interpretation and management of clinical systems for example extreme paranoia, persecutory ideas and sleep disturbance, and their potential consequences.
8. The Trust should ensure that staff understand the role of care planning as a clinical activity and ensure that the process of implementation, evaluation and review is fully embedded. This must include the ability to make adjustments to the care plan in response to changes in condition.
9. The Trust must consider ways of ensuring that cultural issues and their relationship with therapeutic interventions are understood. This must include information for staff on the implications of the issues people who have sought, or are seeking, asylum may be dealt with and how to address them in therapeutic relationship.
10. The issue of receiving a timely response from other specialities when seeking treatment advice needs to be discussed and agreed with the Acute Trust.

Monitoring and Observation

11. The operational effectiveness of the Observation Policy should be reviewed with a view to possible streamlining for ease of use. The policy should be renamed 'Observation and Engagement Policy' to fully reflect its purpose.

Clinical Environment

Working practices

12. The managers of the service should review the working practices of the clinical team to ensure that all professionals are achieving their potential and challenging traditional methods. This should include an exploration of how alternative approaches to ward rounds/reviews may be developed to embrace the needs of professionals, patients and carers.

13. The Trust should undertake a staffing and skill-mix exercise to ensure that the appropriate range of competencies exist for diagnosis, care planning, and treatment plans to improve risk assessment and management processes. This should include engaging with commissioners to achieve a wider multi-professional skill mix (e.g. occupational therapy and psychological therapies) in order that patients who are experiencing severe and complex problems can access a richer set of skills and knowledge.

14. The Trust should re-assess the nurse staffing levels taking into account the changing nature of an acute assessment ward in relation to developments such as the introduction of the crisis resolution and home treatment service.

15. The Trust should look at the outcome of the *New ways of Working* pilot sites and evaluate the feasibility of introducing the positive lessons learnt in other parts of the organisation.

16. All temporary staff should have the same access to training and induction as permanent staff.

17. The Trust should continue with its revised approach to engaging clinical staff in changes to services, refurbishment and new builds of clinical environments.

18. The initiative to produce a policy on the production of policies is noted and this should aim to resolve the issue of the effective implementation of policies and procedures by staff using them in their day to day work.

19. The Trust should radically revise its arrangements for access to and provision of clinical supervision on a regular basis for all staff working in acute services.

20. The Trust should expand its arrangements for post-serious incident support to staff and provide a menu of options from which people can select the ones that they feel would be of most benefit to them.

Clinical Records and Communications

21. The quality of communication in the nurse-handover meetings needs to be reviewed to ensure that relevant information, particularly in relation to the risk associated with new patients and changes to care plans are effectively and efficiently transmitted.

22. The Trust should carry out an audit of the calibre of record keeping against agreed standards which relate to such things as the legibility, accuracy and thoroughness of record keeping and their use as a clinical record.

23. The current project to look at the introduction of integrated notes and the Trust's commitment to NCRS is noted and encouraged.

24. Arrangements need to be put in place to ensure that medical records can be accessed out of hours on the Birch Hill Hospital site.

Privacy, Dignity and Safety

25. Using nationally agreed guidelines the Trust should carry out a full review of its arrangements for ensuring the privacy and dignity of patients in its care. This should include the arrangements for the protection of those who are vulnerable and gender segregation.

26. The Trust should audit its standard of safety, privacy and dignity in clinical areas against the following:

- the recently published DoH guidance *"Privacy and Dignity-the elimination of mixed sex accommodation"* Institute of Innovation and Improvement NHS 2007;
- the Royal College of Psychiatry Professional Guidance;
- the impending CSIP/NIMHE Guidance on womens' safety;
- the impending Chief Nursing Officer Guidance on mixed sex wards;
- the impending CSIP/NIMHE Guidance on safer services and the management of violence and aggression in inpatient settings.

27. The Trust should have robust policies in place and exercise appropriate supervision during patients' stay in hospital and ensure that individuals are protected fully during this difficult phase in their lives. The Protection of Vulnerable Adults Policy should be fully implemented and closely connected to the Essence of Care Benchmark in Safety, Privacy and Dignity and the Risk Management Policy.

28. The Trust should continue with its proposals to improve the physical ward environment particularly in relation to improving lines of observation and the alarm system

29. The routing of emergency services to the correct part of the Birch Hill Hospital site is being addressed but requires an early resolution.

14.6. Progress against the Trust Internal Review Action Plan

Prior to the completion of the internal review the Trust had carried out the actions set out below.

1. The three rooms that were between the female area and the general part of the ward that had been used for either male or female patients was re-designated for female patients only. Swipe cards were issued to regulate the access to female-only sleeping areas. A child visiting and a multi-faith room was also being explored for each inpatient area on the Birch Hill site.
2. All bedroom doors were in the process of having vistomatic panels fitted to aid observation of patients.
3. A review was commissioned into the effectiveness of the ward alarm system.
4. The Trust set up a project to look at the feasibility of introducing integrated records.
5. Access of emergency services to Birch Hill Hospital using satellite navigation systems was in discussion as current post coding systems were found to be sending people to the wrong entrance of the hospital site.
6. Security was increased to provide two security guards to the site 24/7 with the facility to access a third guard when the service requires it.
7. The Trust implemented the STAR risk proforma as part of the Care Programme Approach.

Post Internal Review the Trust has carried out the following actions (the text in italics represents work that still requires completion):

1. Significant changes were made to the Hollingworth Ward environment.
2. The process for patients to be transferred from Accident and Emergency with their notes was agreed. This process was audited at three and six month intervals following the change to assess the effectiveness of the new practice implementation.

3. The STAR risk assessment process was implemented by the Trust in 2007. It has been audited on a regular basis since this time. *However the Independent Investigation Team found that risk assessment processes were still neither understood, nor implemented appropriately by all multidisciplinary team members on Hollingworth Ward.*
4. A cultural competence training programme was developed in 2006 and the internal review action plan was to target it towards staff on inpatient wards. *At the time of the Independent Investigation it was evident that inpatient staff, both nursing and medical, still had a poor understanding of cultural diversity needs and people who are, or have been, asylum seekers.*
5. The observation policy was reviewed using best practice guidelines.
6. The ward nursing establishment was reviewed following the incident. *However New Ways of Working has to still to be implemented and was due to commence in February 2011.*
7. The internal review action plan stated that all staff had to have access to clinical supervision. The action plan stated that all Trust staff have access to clinical supervision and that a policy was in place. *Nursing staff on Hollingworth Ward explained to the Independent Investigation Team that a clinical supervision process was in place, however it was difficult to ensure all nursing staff complied with it/had enough time to attend.*
8. The review of the policy on producing policies was conducted in March 2008. Additional work was completed in September 2008.
9. The review of ward-based handovers was addressed by the appointment of a Modern Matron who had a lead role regarding this issue.
10. With regards to the quality of clinical record keeping the Trust conducted an audit of medical records. *However clinical records are still not integrated, the Trust switched over to an electronic record system in February 2011 which should address this issue in the long-term. However access, integration and quality issues may remain as these would appear to be cultural issues as much as process issues.*
11. The dignity and privacy review was achieved by assessing service against Health Care Commission Standards. A Department of Health self assessment on dignity and privacy was undertaken in May 2008.

12. The supervision of vulnerable adults whilst in hospital was addressed by the development of a Vulnerable Adults Policy in 2008. The Trust internal review action plan states that ongoing monitoring of this policy was proposed.

13. Issues regarding Emergency Service use of satellite navigation systems was addressed by informing the emergency services of the problem.

The Independent Investigation Team recommendations will support the completion of any outstanding internal review recommendations and will also consolidate those recommendations that have been completed by ensuring that a full audit takes place to assess the effectiveness of the implementation to date.

15. Health and Safety Executive Investigation

The Health and Safety Executive

The Health and Safety Executive (HSE) is the national independent watchdog for work-related health, safety and illness. It is an independent regulator and acts in the public interest to reduce work-related death and serious injury across Great Britain's workplaces.[139]

Events Following the Incident

Following the death of Ms. X RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) documentation was completed and sent to the Health and Safety Executive. RIDDOR reporting is required when a death, major injury, or dangerous occurrence occurs in the workplace affecting either an employee or a member of the public. In cases of this kind the Health and Safety Executive (the enforcing authority) must be notified without delay.

The HSE requested Mr. Z's clinical records to be sent to them. This was done in October 2007 following the Trust taking legal advice.[140] The HSE, the Police Service and the Trust set up a Joint Agency Group which met on several occasions to address multi-agency issues.

Health and Safety Executive Recommendations

The following actions points were required of the Trust by the HSE.

Clinical Risk Assessment

1. Clinical staff required training on the STAR risk assessment system.
2. STAR risk assessments and risk management plans needed to be completed in accordance with a consistent protocol.

Assessment of the Patient Environment

3. Health and Safety issues needed to be assessed as part of service users' inpatient care plans. Assessment and control measures were required in accordance with Regulation 3 of the Management of Health and Safety at Work Regulations (1999).

139 Health and Safety Executive Website Home Page
140 Trust Investigation Archive. Rochdale Documentation P 4

4. The existing [at the time of the incident] Health and Safety inpatient audits required a more robust approach as they did not address the management of violence and aggression adequately.
5. The remote location of the ward kitchen, patient dining area access, and general alarm systems required priority action.
6. Alarm improvements, visual access, and swipe card access to female rooms was required.

Training

7. Training was required for untrained/agency staff in physical interventions in relation to aggressive and violent behaviour.
8. In accordance with Regulation 5 of the Health and Safety at Work Regulations (1999) the Trust was required to audit their management of violence arrangements.

Trust Completion of Action Points

Clinical Risk Assessment

The Trust responded to this with reviews of policy and process and training events. However the Independent Investigation Team found that some members of the multidisciplinary team were *still* not aware of their obligations with regard to risk assessment.

Assessment of the Patient Environment

All required improvements to the ward environment have been made. However the ward does lend itself to further improvements with regard to visual access and observation sight lines.

Training

The Trust conducted reviews and audits.

The Independent Investigation Team recommendations will support the completion of any outstanding HSE action points and will also consolidate those recommendations that have been completed by ensuring that a full audit takes place to assess the effectiveness of the implementation to date.

16. Notable Practice

During the course of the Independent Investigation four main points of notable practice were identified.

16.1. The Management of the Resuscitation of Ms. X

A sudden death on an acute inpatient psychiatric unit, whilst not a unique event, is an uncommon event. Whilst the resuscitation attempt on Ms. X was sadly unsuccessful, it should not deter from the fact that the ward staff acted in an exemplary manner. The resuscitation process was managed with efficiency and professionalism, made more notable by the fact that the ward team also had to continue its care and management of Mr. Z and the other service users on the ward.

16.2. Trust Clinical Governance Structure

Ward to Board Culture

The Independent Investigation Team were impressed by the energy and enthusiasm that it encountered within the Pennine Care NHS Foundation Trust and can verify that the corporate Trust Board vision was both understood and championed by all of the people that we met during the course of our work regardless of their grade or profession.

Pennine Care NHS Foundation Trust has embraced the ethos of a Ward to Board culture and has embedded Governance across the organisation. The Trust operates an integrated governance model to assure both quality and patient safety is maintained. The Trust has also adopted service line management models for service delivery and a key emphasis of this approach is clinical engagement and clinical leaders driving the Trust's strategy and care delivery.

The integrated governance model underpinning a Ward to Board culture includes the notable best practice examples set out below.

- A meeting structure from local services up to the Board with shared terms of reference and dashboard reporting; the Trust has local governance arrangements feeding into a Divisional Integrated Governance Group, these groups report into the

Trusts Integrated Governance Group, which is chaired by the Chief Executive and is a formal sub-committee of the Board.

- The Integrated Governance Group oversees all corporate and clinical governance, bringing together safeguarding, serious untoward incident reporting, complaints, litigation, learning and development, risk management, risk register, health and safety, infection control and all relevant aspects and Care Quality Commission requirements to maintain patient safety. Non Executive Directors attend the meeting and have open invitations to attend any of the feeder meetings or to scrutinise any aspects of governance.
- The Divisional Integrated Groups follow the same structure and its membership is made up of local service management and clinical leadership. This group ensures action is taken locally to address concerns, to drive service improvement and to ensure the Board is aware of issues of concern or risk.
- The Deputy Director of Nursing and lead for integrated governance coordinates all of the clinical governance activities and has a dynamic role working with service directors and local governance leads to ensure effective governance is in place. This role works closely with the Head of Corporate Governance to ensure complaints, litigation, legal and coroner inquests are linked to clinical governance in services.
- The Trust has developed a Patient Safety Improvement Group which has clinical and corporate membership and meets weekly to review all serious untoward incidents (grades 4 and 5). Its aim is to ensure that learning is identified to improve systems and the quality and safety of patient care.
- Learning points from SUIs are shared with the Integrated Governance Group, the Divisional Integrated Governance Group and wards/teams.
- A more detailed quarterly report is published and fed through the groups highlighted above and focuses on the lessons learnt, root cause analysis, complaints and audit reports.
- These themes are then incorporated into the training and development plan via the Educational Governance Group.
- The Trust has also developed and published its quality accounts which outline the key quality indicators to ensure continuous improvement within services. These indicators are prioritised around the key areas of safety, effectiveness and patient

experience and improvements are monitored via the integrated governance group, the quality group, and the divisional governance groups in collaboration with the wards.

The Trust Board receives a monthly integrated governance dashboard and quarterly detailed reports. In addition the Board has development sessions and training on areas such as health and safety, child safeguarding, Care Quality Commission standards and quality and patient safety. In addition to this the Board has regular updates on the risk register and scrutinises items on this register. In 2010 the Board had two main development sessions focusing on the recommendations of the Francis Inquiry and agreeing an action plan to respond to those recommendations.

Finally, the Board (both Non Executive Director and Executive Director members) participate in a Trust-wide clinical presence programme. This co-ordinated programme timetables attendance by Board members to service visits and to spend time with clinicians. This is to ensure the Board is visible, meets staff regularly and hears direct accounts of the challenges clinicians face in practice. As a consequence these visits are discussed at Board and in Executive Director meetings and where needed actions are progressed as a direct response to issues raised by staff.

Each ward and clinical area receives a regular report in relation to their clinical governance performance. This ensures that every clinical team has the information that it needs to improve local performance. It also ensures that staff feel connected into the clinical governance process as information flows in a practical manner that is literally Ward to Board, and back again.

16.3. Staff Support and Involvement

In General

Since 2006 the Trust has adopted an Organisational Development framework to ensure staff are supported, involved and engaged to ensure the Trust has the best workforce possible to deliver safe and effective care. It is a fundamental belief of the Trust that the best supported staff deliver the best services.

The strategy for Organisational Development has followed an Appreciative Inquiry approach and is underpinned by the principles of Emotional Intelligence and Mindfulness. However, as

a Trust these theoretical models sit behind actual implementation and action to support staff. The following are key features of the Trust approach to Organisational Development:

- launching a strategy and making a clear 'pledge' to support and engage staff and to act upon their views and values to make the Trust a great place to work;
- taking action on a 'You said, We did' approach across a range of initiatives;
- the development and implementation of a health and wellbeing strategy to support and promote physical and mental wellbeing in work;
- setting up and running a professional coaching service for staff;
- developing a leadership development programme which has now provided support to over a 150 senior and middle managers;
- setting up an Education Governance Group and a Learning and Development department to provide education and Organisational Development services;
- delivering clinical skills training programmes;
- driving up access to university-based education;
- running Organisational Development events large and small to engage staff and communicate widely on Trust business and strategy;
- running professional engagement events;
- hosting Chairman and Chief Executive lunches; inviting a wide range of staff to meet the CEO and Chairman to discuss challenges and celebrate success;
- celebrating success with a series of Trust awards and events to recognise outstanding contributions to patient care;
- being nominated and winning several nationally recognised awards;

These are just some notable examples of organisational development in Pennine Care NHS Foundation Trust. Importantly it is a core principle by which the Trust runs its NHS business; that the most effective outcomes are achieved through the close involvement of the workforce in developing strategy and delivering change. The best ideas and successes in Pennine Care have been generated by the clinical staff who are closest to the patient care pathway.

Following the Incident

The Trust was able to demonstrate its staff support approach in action by the way that it sustained the support of its staff throughout the incident itself, the internal review and Independent Investigation Process.

During the management of the incident on the 13 August 2007 senior management were immediately available to offer practical help and support to the ward. In the immediate aftermath of the incident the Trust CEO and other members of the Top Team came onto the ward to offer support and provide coordination. Staff continued to receive support throughout the ensuing investigation processes and it was evident that this approach was both appreciated and effective.

16.4. Hollingworth STAR Wards Programme

The Trust has now implemented the productive ward series across thirteen of its 27 wards. The essence of productive wards is to create the time to care. Star Wards is a programme to help teams focus on how best to exploit the additional time they release to care.

The productive ward is an approach built around 'Lean Thinking'. It is owned and led by the ward team themselves and it guides teams through a series of modules. Hollingworth Ward was the first ward to be chosen to 'showcase' the productive ward approach. It was chosen as it had already adopted Star Wards. Star Wards has three simple approaches, developed by Marion Janners OBE, a service user and a champion for good mental health services. The three approaches aim to improve the therapeutic experience of in-patients in mental health wards; they are tweaking (simple changes that don't require investment and that you can do today, turning (making changes with some planning and minimum investment) and transforming (wholesale change and redesign to invest in comprehensive therapeutic programmes).

Across the Trust, championed by Hollingworth Ward, there is now a therapy programme active on every ward and following £500,000 reinvestment into therapy by the Trust, whole new groups of practitioners to drive up therapy on the wards. As a result of this investment a number of therapeutic groups are available including physical health and wellbeing, social inclusion, hearing voices, managing emotions, and further educational groups.

17. Lessons Learned

The Independent Investigation Team found that the Pennine Care NHS Foundation Trust worked within sound frameworks and procedures. However there are several lessons for learning that have been identified from the examination of the care and treatment that Mr. Z received. These lessons will have a resonance for all mental health Trusts across the country who are faced with similar issues. The principal lessons are set out below.

The Care and Treatment of Asylum Seekers

As has been set out in subsections 12.1.2., 12.1.8. and 12.1.9. the Department of Health, the Home Office and the National Institute for Health and Clinical Excellence have developed a series of guidelines to support the mental health care and treatment of asylum seekers and refugees. The needs of these people can be multifaceted and it is essential that services are able to provide specialist services that can address the often complex requirements of this group. This is an issue for both the commissioners and the providers of mental health services across the country. It is essential that the national guidelines are followed as this particular group of individuals can be managed in an inappropriate manner that can endanger not only their recovery but their safety, and the safety of their families back in their country of origin. (Please see the national guidance and the subsections that address this issue in the main body of the report).

Cultural Diversity and Patient-Centred Care

The concept of cultural diversity is now embedded well into most NHS provider organisations. However the effective management of cultural diversity is a challenging and often highly specialist area. Individuals, such as Mr. Z, who come from countries that are not widely known about or understood well can be subject to a ‘stereotypical’ set of assumptions and beliefs. It is essential that NHS staff approach all such individuals with an open mind and endeavor to take the best advice possible with regard to:

- communication;
- enculturation of the service user into an NHS care and treatment environment;
- culturally appropriate and acceptable assessment, care and treatment programmes.

At the heart of this case was the need to place the patient at the centre of the care and treatment offered. It is essential to engage with each individual patient and to build up a therapeutic relationship with them. This is taught at the beginning of every student nurse and medical student's basic training. However it is a lesson that often needs to be repeated and underlined as practitioners graduate throughout their working lives.

Assessment and Diagnosis

The taking of a psychiatric history and the formulation of a comprehensive clinical assessment is fundamental to the delivery of safe and effective care. It is not possible to make a diagnosis with any degree of credibility if this is not achieved first. Clinicians must ensure that assessments are:

- culturally appropriate;
- timely;
- comprehensive;
- dynamic;
- multidisciplinary;
- communicated well;
- documented.

The information that is ascertained from assessment (to include risk assessment) should be robust enough to be able to inform holistic and patient-centred care and treatment plans.

The Challenges of Running Services from a Small Hospital Site

Over the past 25 years there has been a conscious movement away from the provision of mental health services from large campus sites. Currently most inpatient services are provided from relatively small units. There are distinct challenges in providing specialist secondary care inpatient services from small sites. They are:

- the increased costs of commissioning a comprehensive, evidence-based service from a small site;
- ensuring the critical mass of staff over a 24 hour seven-day-a-week period to ensure the safe management of the site and emergency situations;
- ensuring the built environment is appropriate to the safety, privacy and dignity, and therapeutic care needs of mental health service users.

Commissioners need to be aware of the additional costs of providing a safe and clinically effective range of mental health services from small sites. It is not simply the safety of the service that needs to be considered but the integrity of the service also.

The Sub-Audit 'Blind Spot'

Clinical governance systems and processes can ensure the safety and effectiveness of service provision. However there are some practices, or omissions in practice, that can be considered so basic that they are not audited.

The failure to elicit an adequate history that was factually accurate and incorporated everything that was then known about Mr. Z ensured that this individual was not understood in his full context and as such remained partially treated and his full potential risk never understood.

The failure to take Mr. Z's *full* history at the outset of his contact with mental health services is not the kind of thing that would normally be detected by clinical audit, no matter how robust. This kind of factor is probably something that could best be described as being at 'sub-audit' level in most organisations. Clinical audit often assumes that some actions are so basic and fundamental to clinical practice that the audit standards do not necessarily detect their absence or measure their full effectiveness.

18. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Pennine Care NHS Foundation Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

18.1. Pennine Care NHS Foundation Trust

The Executive Directors of Pennine Care NHS Foundation Trust had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already made.

18.1.1. Ward Environment

- ***Contributory Factor Number 1 (Influencing). Environmental factors came together on the 13 August 2007 in such a way that they contributed to the attack on Ms. X occurring and also going undetected.***

Since the time of the incident the Trust has implemented in full the recommendations from the internal review. Contributory factor Number 1, cited above, no longer holds relevance for the current service provided on Hollingworth Ward. This Independent Investigation has been able to conduct a high-level safety review. The outcome of this review was that the ward provided services in a safe environment which also offered a high level of service integrity. There were some deficits identified and the recommendations set out below address them.

1. The Trust should review the emergency out of hours procedures and protocols and make formal written arrangements with each of the 'blue light' services.

2. The Trust should remove the old nursing station and provide a seating area for patients and staff**.**

18.1.2. Diagnosis:

- ***Contributory Factor Number 2 (Influencing). The failure to assess Mr. Z within the context of his personal history and presenting symptomology led to a delay in providing him with an appropriate care and treatment plan. Delayed and inappropriate assessment also ensured that his condition was not considered in the full light of everything that was known about him at the point of his admission to the ward.***

3. The Trust should commission and develop a multi-disciplinary (MDT) and clinical skills programme specifically designed to focus on the complexity of cases with:

- asylum seeker status;
- Post Traumatic Stress Disorder in terms of assessment, diagnosis, formulation, care and treatment.

18.1.3. Medication and Treatment

- ***Contributory Factor Number 3 (Influencing) . The care and treatment plan offered to Mr. Z was not based upon a comprehensive or coherent assessment process. Consequently it was not possible to understand exactly what problems the clinical team were hoping to affect. The clinical team did not have a clear formulation of Mr. Z's problems and did not identify any clear goals for treatment. One may not expect depressive or psychotic symptoms to be abated in 13 days. However Mr. Z's anxiety, fear, agitation, restlessness, poor sleep and overall distress could have been managed more effectively.***

4. The Trust should continue implementing *New Ways of Working* (NWW) in all acute wards to ensure an effective full daily multidisciplinary team (MDT) review of all patients' care and treatment. In order to achieve this the MDT will also need to:

- be subject to a full skill mix review which is undertaken in conjunction with commissioning bodies;
- consider how best to deliver a comprehensive range of evidence-based care and treatments in line with the National Institute for Health and Clinical Excellence (NICE) Guidance. This to include the challenges of incorporating a wider skill mix to comprise occupational and psychological therapy.

5. The Trust should ensure that the MDT review encourages collaborative decision making whilst maintaining clear lines of accountability and responsibility for both the overall care and treatment plan and the individual elements of it.

6. The Trust should ensure the implementation of the electronic care record supports and enhances MDT working.

7. The Trust review should examine the effectiveness of the MDT process six months post implementation/following the publication of this report, whichever occurs first.

18.1.4. Use of the Mental Health Act (83 and 07)

- ***Service Issue Number 1. The Trust did not distinguish between the rights of informal and voluntary patients. Admission processes were not clear and would serve to potentially mislead both clinicians and patients alike.***

8. The Trust should consider making the distinction between Voluntary and Informal patients on admission documentation. This to include:

- policy revision and documentation revision as required;
- the requirement for the assessment and documentation of capacity of all service users on admission who are not admitted under detention.

18.1.5. Care Programme Approach (CPA)

- ***Contributory Factor Number 4 (Influencing). The failure to provide CPA to Mr. Z meant that he did not receive a comprehensive and holistic assessment. This in turn ensured that he was never understood fully in the context of his personal history, social care needs and cultural background. This contributed to the failure to provide Mr. Z with the interventions and support that he needed.***

The Trust has undertaken a great deal of work in relation to the Care Programme Approach (CPA) since the time of the incident and has in place a comprehensive action plan that is overseen by the Trust CPA steering group.

9. The Trust should implement the recommendations and action plan of the CPA steering group and re audit compliance 12 months following its implementation/ or the publication of this report, whichever comes first. This review should:

- ensure that service users who are previously unknown to the service and make their first contact via an inpatient admission receive CPA as required in a timely manner;
- ensure that assessments are holistic and address needs that are both social and cultural;
- ensure that care planning is patient-centred and involves the service user as much as possible.

18.1.6. Risk/Clinical Assessment

- ***Contributory Factor Number 5 (Influencing). Mr. Z was not assessed within the context of a comprehensive and dynamic risk assessment process. This ensured that Mr. Z was not understood within the context of his presenting symptomology and no appropriate management plan was either developed or implemented.***

The reader is asked to refer to the recommendations already set out under Medication and Treatment and the Care Programme Approach above. The internal review identified the need for *all* clinical staff to be made aware of their roles and responsibilities with regard to risk

assessment. The Independent Investigation Team found evidence to suggest that this was still an outstanding issue, particularly with medical staff.

10. The Trust should extend the terms of reference of the CPA steering group to include processes relating to the new Trust Approved Risk Assessment (TARA) and the new Trust-wide Pennine Assessment Document (PAD). This to include:

- a restating of the clinical roles and responsibilities of all clinical staff, both individually, and as a part of the MDT, to take part in risk assessment. This to include the requirement of the utilisation of formal Trust documentation;
- an audit to establish both the compliance to and the quality of risk assessment processes.

18.1.7. Referral, Admission and Handover Process

No recommendation required.

18.1.8. Service User Involvement: Cultural Diversity

- ***Contributory Factor Number 6 (Influencing). Mr. Z was not assessed and treated within the context of his personal history and cultural background. His vulnerabilities as an asylum seeker with emergent mental health problems were not understood and Mr. Z was assessed in a culturally inappropriate manner that failed to identify his care and treatment needs.***

The reader is asked to refer to the recommendation under set out Diagnosis above.

11. The Trust should provide training to highlight the importance, during assessment, diagnosis and treatment, of the patient's cultural background. This to include the requirement for:

- a secondary literature review to be conducted if required;
- specialist referral if required.

12. The Trust should develop a system to provide the clinical team with access to any required cultural information and external support agencies. The Trust should:

- develop community outreach and inreach initiatives with the local community in order to establish culturally appropriate liaison;
- ensure appropriate links are made with different faith groups to ensure that the chaplaincy service represents the needs of service users;
- provide literature and advice notes in a range of appropriate languages;
- arrange more timely interpreter access.

18.1.9. Service User Involvement: Care Planning and Treatment

- ***Contributory Factor Number 7 (Influencing). Mr. Z did not receive the kind of patient-centred care that would have aided either his short-term care and treatment or long-term recovery. This served to exacerbate his isolation and ensured that he remained an unknown quantity to the clinical team.***

The reader is asked to refer to the recommendation set out above for the Care Programme Approach. The Independent Investigation Team acknowledges the excellent work that has been carried out on Hollingworth Ward with the Productive Ward and STAR Wards initiative. This has been extremely successful in ensuring that patients are not isolated and that staff engage fully with them in a therapeutic manner.

13. The Trust should consider rolling out the Productive Ward and STAR Wards initiative to all other inpatient units within the Trust.

18.1.10. Documentation and Professional Communication

- ***Contributory Factor Number 8 (Influencing) . The decisions about the care and treatment of Mr. Z were not based on the best evidence available to the Clinical Team at the time. As a result Mr. Z did not receive the care and treatment that he required.***

The reader is asked to refer to the recommendations set out under Medication and Treatment and the Care Programme Approach above. The Trust introduced in February 2011 an electronic record system that will rectify some of the inherent system issues that holding separate uni-professional notes present.

14. The Trust should audit the effectiveness of the new electronic record system on a random sampling basis at six monthly intervals for the first year of running and on an annual basis thereafter.

18.1.11. Overall Clinical Management of the Case

- ***Contributory Factor Number 9 (Causal). The level of care and treatment that Mr. Z could reasonably have been expected to receive was not delivered. Risk management and evidence-based care and treatment can reasonably be expected to improve mental health and reduce risk. This factor was under the direct control of the clinical team and therefore the team retained a high degree of influence over the mental health of Mr. Z and thereby the circumstances that led to the killing of Ms. X.***

The reader is asked to refer to all of the recommendations set out above that address care and treatment issues. These recommendations combine together to address the issues raised under the clinical management of the case heading.

18.1.12. Resuscitation/Medical Emergency Process

- ***Service Issue Number Two. An inherent system failure was identified as the result of the Independent Investigation regarding the procedure required to call an ambulance for assistance to emergency situations. It was evident that there was confusion with regard to the emergency call out system in that a combination of 999 and 444 procedures were interchangeably used.***

15. The Trust should ensure that policies and procedures are developed with:

- the ‘blue light services’ and that arrangements are formally agreed with them; and

- that the revised policies and procedures are incorporated into all statutory training events; and
- protocols to support emergency actions are produced on a simple A4 format and placed in an easily accessible place in each clinical area.

18.1.13. Clinical Supervision

- ***Service Issue Number Three. Poor clinical supervision practice was evident on Hollingworth Ward at the time Mr. Z received his care and treatment.***

16. The Trust should ensure that all Trust employees are aware of the *requirement* to take part in clinical supervision. This requirement should be made explicit and compliance should also be audited on a regular basis.

18.1.14. Adherence to Local and National Policy and Procedure

- ***Contributory Factor 10 (Influencing). The Trust policies and procedures were found to be of an excellent quality, however adherence to them was found to be poor with regard to clinical record keeping and clinical assessment (including risk assessment). National best practice guidelines pertinent to the management of Mr. Z were not followed.***

The reader is asked to refer to the recommendations under Diagnosis, Medication and Treatment, the Care programme Approach, Risk Assessment, and Service User Involvement and Cultural Diversity.

19. Glossary

Asylum Seeker	An asylum seeker is a person who, from fear of persecution for reasons of race, religion, social group, or political opinion, has crossed an international frontier into a country in which he or she hopes to be granted refugee status.
Caldicott Guardian	Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information.
Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Case Management	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Citalopram	Citalopram works by helping to regulate serotonin levels in our body, easing the symptoms of depression and feelings of panic.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Ibrobrufen	Ibrobrufen is a non-steroidal anti-inflammatory drug (NSAID) prescribed for pain relief.
Mental Health Act (83)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.

Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.
Olanzapine	Olanzapine is an anti psychotic drug used in the treatment of schizophrenia and bipolar disorder.
Paranoid Schizophrenia	Paranoid schizophrenia is the most common type of schizophrenia in most parts of the world. The clinical picture is dominated by relatively stable, often paranoid, delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances.
Personality Disorder	Personality disorders are typically associated with severe disturbances in the behaviour of an individual, usually involving several areas of the personality, and are nearly always associated with considerable personal and social disruption. Additionally, personality disorders are inflexible and pervasive across many situations. This behaviour can result in a person adopting maladaptive coping skills, which may lead to personal problems that induce extreme anxiety, distress and depression.
Post Traumatic Stress Disorder (PTSD)	PTSD is a type of severe anxiety disorder. It can occur after you've seen or experienced a traumatic event that involved the threat of injury or death.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually

	including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom.
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.
Thought disordered	This is one of the symptoms of psychotic illness where thoughts and conclusions do not follow logically one from the other.
Trazodone	Trazodone is an antidepressant medication. It is thought to increase the activity of one of the brain chemicals (serotonin) which may become unbalanced and cause depression. Trazodone is used to treat depression. It may also be used for relief of anxiety disorders (eg, sleeplessness, tension) and chronic pain.

Appendix One

Timeline for Mr. Z

Date	Event	Comment
June 1971	Mr. Z was born in Ethiopia.	
1992	Mr. Z completed his law degree at the University of Addis Ababa.	
1995-1998	Mr. Z worked as Supreme Court Judge in the Gambella Region of Ethiopia.	
1998	Mr. Z was detained by Government security forces together with two other Supreme Court Judges.	
11 October 2005	Mr. Z arrived in the United Kingdom and sought political asylum. At an initial interview Mr. Z said that he had previous mental health problems.	
24 August 2006	Mr. Z lost his first application for asylum as his story was not believed.	
19 September 2006	Mr. Z lodged an appeal against the decision to refuse him asylum.	
7 November 2006	Mr. Z's appeal was allowed.	
15 January 2007	Mr. Z was granted asylum and leave to stay in the United Kingdom until 15 January 2012.	
	Sometime during this period Mr. Z came to live in Blackburn and registered with a General Practice in the Blackburn area.	
14 May 2007	Mr. Z's GP prescribed him with 28 Trazodone Capsules 50mg.	The Independent Investigation Team could not access these records in order to learn why this was done.
5 June 2007	Mr. Z commenced residency at Leopold Court, a homeless persons' hostel in Rochdale.	
12 June 2007	Mr. Z registered with a General Practice in Rochdale. Mr. Z was assessed and it was recorded that he had been a political prisoner for several years and that he had been subject to torture. Mr. Z told the GP that he was depressed and the GP referred him for psychology services.	This was a reasonable thing for the GP to consider at this stage.
1 August	Mr. Z was taken to Rochdale Infirmary via an ambulance. Staff at Leopold Court had	

2007	grown increasingly worried about his behaviour. He had been lying in his bed all day crying and it was reported that he was afraid of people and that he kept his windows and doors locked in order to keep them out. It was evident on his arrival at Accident and Emergency that he was markedly distressed, he was referred to the Access and Liaison Team for a psychiatric assessment. On assessment by the on call psychiatrist Mr. Z said that he would have to *"kill myself or kill them".* The initial diagnosis was that of psychotic depression. It was decided to admit Mr. Z to Hollingworth Ward, an acute psychiatric inpatient assessment unit. Mr. Z was admitted onto the ward at 20.00 hours. On his admission a Named Nurse was allocated to him and conducted a STAR risk assessment and completed assessment documentation. The Named Nurse decided to nurse Mr. Z on 15 minute observations. Mr. Z was not admitted with any medication. Mr. Z's history of imprisonment and torture was recorded. It is unclear whether or not the Accident and Emergency notes arrived with Mr. Z, however the on call doctor who assessed Mr. Z came onto the ward and discussed the case with the nursing staff. At this stage *"?psychotic depression / PTSD"* was written in the nursing notes.	Based on Mr. Z's paranoid state the decision to commence him 15 minute observations was a sensible one.
2 August 2007	A care plan was written based on the risk assessment formulated the previous day. At this stage the identified risks were in relation to Mr. Z harming himself, not to any risks he potentially posed to other people. A range of therapeutic nursing interventions were identified, with particular emphasis to engage Mr. Z with ward activities and to prevent isolation. It was noted that Mr. Z had some paranoid ideas. A ward round was held to which the Consultant Psychiatrist and Named Nurse attended (it is unclear who else attended as this was not recorded). The plan was to observe Mr. Z for two days prior to commencing him on medication, and for a Hamilton Depression Rating Scale and BPRS.	No discussion took place in relation to any possible PTSD or to Mr. Z's complex personal history. No mention was made regarding Mr. Z's statement in Accident and Emergency about having to *"kill myself or kill*

		them".
3 August 2007	Mr. Z was noted to isolate himself. He was described as being pleasant, with no suicidal ideation. No issues or concerns were reported.	
4 August 2007	A Hamilton Depression Rating Scale and BPRS was conducted by the Named Nurse. Mr. Z was noted to have slept well. He had a flat affect but did not appear to have any paranoid ideas. Mr. Z continued to isolate himself.	These rating scales would have been invalidated by Mr. Z's ethnic background. No attempts appear to have been made to engage therapeutically with Mr. Z.
5 August 2007	There were no reports of suicidal ideation or paranoid ideas.	No attempts appear to have been made to engage therapeutically with Mr. Z.
6 August 2007	Mr. Z continued to isolate himself, he came out of his room to eat his meals but did not wish to interact with nursing staff. The Specialist Registrar reviewed Mr. Z and reported him to be low in mood and that he maintained the idea that people wanted to harm him. Mr. Z was commenced with Citalopram 20 mg once daily.	No attempts appear to have been made to engage therapeutically with Mr. Z. The doctor who met with Mr. Z did not conduct any kind of risk assessment or consider PTSD/cultural diversity issues.
7 August 2007	Mr. Z was reported as having slept well. He remained isolative, however he came out of his room in the afternoon and spent time in the ward communal areas. No signs of paranoia or suicidal ideation were detected.	
8 August 2007	Mr. Z was reported as having slept well, but that he remained *" facially flat, blunted affect".* Mr. Z was reported as having had no hallucinations and of spending most of the day in bed.	Once again little attempt was made to engage with Mr. Z and implement his care plan. No progress report was made or care plan evaluated.
9 August 2007	Mr. Z was seen in the ward round by the Consultant Psychiatrist. It was evident that Mr. Z was paranoid and maintained the belief that people were tying to harm him. He thought that people *"think I am a spy"* and that everyone hated him. Mr. Z thought the future was *"black"* and he cried throughout the interview. It was decided to commence Mr. Z on	No discussion took place at ward round about Mr. Z being a risk to either himself or other people, even though by this stage the

	Olanzepine 5 mg once a day for one week, and to raise it to 10 mg the following week. Mr. Z's presentation on the ward remained the same.	Accident and Emergency notes were probably on the ward. No discussion took place about the possibility of Mr. Z having PTSD. After nine days on the ward no review of his care took place and his care plan was not evaluated.
10 August 2007	Mr. Z's presentation on the ward remained the same.	
11 August 2007	Mr. Z's presentation on the ward remained the same, however he was able to concentrate enough to read a book slowly.	
12 August 2007	Mr. Z was reported as being in distress. He expressed paranoid ideas about people wanting to harm him and voiced the idea that a black man was following him around that he had been hiding regularly in his wardrobe to escape from him. No suicidal ideation was detected.	No review of the risk assessment or care and treatment plan took place.
13 August 2007	Mr. Z was reported as being in distress throughout the night. He had paranoid ideas about people wanting to harm him and could not settle. The on call doctor was called who prescribed Olanzapine 5 mg prn. It was decided that there were no acute concerns regarding his behaviour. At some stage during the night Mr. Z started to talk about his experience of imprisonment and torture. Sometime in the morning (it is not noted when) the Specialist Registrar visited Mr. Z. It was recorded that Mr. Z wanted to remain in his room and that he had been distressed in the night. The plan was to continue with the antipsychotics and to encourage him to spend time out of his room. Mr. Z was distressed during the afternoon and remained in his room. At 17.30 hours Ms. X was found collapsed on the floor of the female lounge. Mr. Z admitted to having strangled her. An ambulance was called at 17.32 Hours and the ward nursing staff commenced	No review of the risk assessment or care and treatment plan took place. This was conducted in a

	resuscitation processes. At 17.45 Hours the ambulance crew arrived on the ward. The Police arrived on the ward at 18.14 hours Mr. Z was arrested and taken into police custody at 18.16 hours. Ms. X was pronounced dead at Rochdale Infirmary at 18.28 hours.	professional manner
14 August 2007	The Police took witness statements and Mr. Z remained in Police custody.	
7 February 2008	Mr. Z pleaded guilty to manslaughter on the grounds of diminished responsibility when his plea was accepted.	
17 April 2008	Mr. Z was sentenced at the Manchester Crown Court to indefinite detention. His place of disposal was Ashworth High Security Hospital.	

Appendix Two

Health and Social Care Advisory Service

Safety Review Proforma

Hollingworth Ward
December 2010

NB the following standards relate to safety and therapeutic environment issues only.

Standards have been taken from the Accreditation for Acute Inpatient mental Health Services (AIMS) Royal College of Psychiatry (2009 update), the CSIP National Institute for Mental Health in England *Onwards and upwards* (2006/7 review), the Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision (1999), Department of Health Dignity Challenge Standards

General Criteria	Met ✓ Partially Met? Unmet ✖	Comments (these may include a robust appraisal of the criteria, and may include any unusual or atypical circumstances relating to the item).
1. Management and Governance of the ward.		
1. The ward has a current, up-to-date operational policy which is available to all staff.	✓	There is an up to date operational policy available to all staff.
2. The ward has appropriate mechanisms for clinical governance.	✓	There is 'dashboard' information displayed in the meeting/ward round room. With the local governance version of the full Trust governance information as presented to the Trust Board. There is a proactive Modern Matron with responsibility for quality issues. Hollingworth Ward receives its own clinical governance data. This data reports on the ward's performance in the following matters: - unplanned staff absence; - number of stressful shifts; - percentage of bank and agency staff used; - medication errors;

		- incidents of self harm; - numbers of absconsions; - numbers of violent or aggressive incidents; - staff activity studies; - interruptions to clinical practice; - time and motion studies; - clinical governance progress charts.
3. Services and practices are appropriately audited and evaluated to ensure quality and efficiency.	**?**	Ward staff could not articulate clearly how the Trust audit programme translates into audit activity on the ward, however data is collected against broad governance themes (see above). The ward could benefit from specific local audits, e.g. clinical records keeping, risk assessments etc.
4. Bed occupancy is managed at a service level, and there is a clear process for exceeding this level.	✓	At the current time five Sector Consultants have beds on the ward but there may be overflows from Moorside Ward upstairs. The organisation is changing: 1. all admissions are now via the Crisis and Home Treatment Team; 2. from February 2011 there will be only one Consultant Psychiatrist responsible for the ward. At the present time the current system works well, it is unclear how the new system will work.
2.0 Clinical:		
1. The service has an up to date, documented policy and procedure for implementing the Care Programme Approach, in line with the guidance contained in *Refocusing the Care Programme Approach (2008).*	✓	The current CPA policy is dated August 2010. It makes reference to *Refocusing* (2008) and to the need for training of care coordinators. Whilst this standard is met there is an acknowledgment by the ward staff that this training needs to be rolled out further. The ward staff are unclear how far this training has been implemented.

2.1 Assessment		
1. Effective service user centred assessment of needs and risks is carried out using established procedures and assessments tools for measuring needs, symptoms, risk and social functioning.	✓	Comprehensive CPA and risk assessment policies are in place which comprise assessment tools. Other kinds of assessment are used on the ward to measure needs, symptoms and social functioning.
2. Service Users are involved in: a. the assessment of need b. the assessment of risk.	**?** ✓	The risk assessment policy does not specifically state that service users should be actively involved in the assessment of their risks. It is unclear how in practice this would be achieved. The CPA policy does require the multidisciplinary team to involve the service user in the identification of their needs. Service users are given copies of their care plans and are actively encouraged to work on their own symptom reduction.
3. Needs assessments are comprehensive covering both health and social needs.	✓	There are comprehensive, clinical, social and physical needs assessment programmes in place on Hollingworth Ward.
2.2 Care planning		
1. All service users have a current care plan.	✓	All service users have a current care plan. Service users are given copies of their care plans and are actively encouraged to work on their own symptom reduction.
2. Service users are involved in and agree their care plan. (signed their care plan).	✓	All service users are involved where possible and hold a copy of their own care plans.
3. All care plans have an identified review date.	-	**Not checked by the Independent Investigation Team as it had no right of access to patients' notes for verification checks to take place. The policy states that this should be the case.**
4. Every patient has a care coordinator in line with the guidance contained in *Refocusing the Care Programme Approach (2008).*	✓	This standard is achieved.

5. Care plans are consonant with the Recovery Model and aim to promote the service user's well-being.	✓	The CPA policy actively promotes the Recovery Model and the assessment of need and development of care plans work within this ethos.
6. The care plans for all in-patients look towards discharge.	✓	The CPA policy would indicate this to be in place. In the case of Mr. Z early contact was made with the CMHT to commence discharge planning. To support this: 1. the ward has a housing worker who has regular weekly sessions and also comes to the ward on an as-need basis. 2. community teams are invited to reviews/ward rounds. It is hoped that after February 2011 there will be a daily planning review which will include the CMHTs
7. Care planning involves appropriate community services.	✓	CMHTs are invited to the reviews.
8. Service users have access to advocacy services.	✓	Hollingworth Ward uses the MIND Independent Advocacy Service. On admission to the ward each service user is given information about the advocacy service. The ward staff actively support/assist service users when accessing this service. Some patients showed the Independent Investigation Team the leaflets on advocacy and reported that these were easy to contact and helpful.
9. Provisions for complying with the Mental Capacity Act are in place: a. Advance Directives; b. informed consent; c. access to IMCA.	✓	Ward staff are aware of the Mental Capacity Act and the MIND advocacy service provides Independent Mental Capacity Advocates (IMCAs). The ward staff have clear policies to work within and also provide appropriate printed material to service users about their rights. The ward staff also support service users in accessing the help and support that they need.
10. There are clear protocols for transfer and discharge.	✓	There are clear transfer and discharge protocols.

11. Service users have access to a pharmacist to discuss medications.	✓	There is a regular weekly slot where service users can book an appointment with the pharmacist to discuss their medication regimen.
2.3 Interventions		
1. Service users have access to an appropriate range of evidence-based interventions (as specified in NICE Guidance).	**X**	There are no psychologists, occupational therapists or social workers allocated to the ward. The nurses carry out some interventions but it is not clear that this would meet NICE guidelines.
2. Interventions are delivered by appropriately trained and supervised staff.	**?**	See above. Despite the fact that service users currently do not have access to a full set of evidenced-based interventions, the staff on the ward are both experienced and skilled to provide a wide range of nursing and social interventions.
3. There is an appropriate range of interventions for the assessment and treatment of people with co-morbid problems of mental health and substance misuse.	**?**	The ward nursing team estimates that *circa.* 25% of service users admitted have co-morbid drug/alcohol problems. There is no inreach from the substance misuse/abuse teams and no dual diagnosis experienced/trained staff on the current multidisciplinary teams. It is unclear how substance misuse issues are addressed.
4. The approach to care is active multi-disciplinary involving users, psychiatrists, psychologists, therapists, nurses, social workers and carers.	**X**	See above. There are only nurses and psychiatrists providing a service on this ward and it is unclear how well they work together. The situation will change in February 2011 when the will be a single Consultant dedicated to the ward as part of the *New ways of Working* programme.
5. A full multi-disciplinary review/ward round occurs at least once a week.	**X**	There are weekly reviews but see above. The nursing staff are hoping to have a daily review supplemented by CPA reviews post February 2011.
6. The service user participates in his/her regular review with appropriate support.	✓	Service users participate either with the support of the Named Nurse, Care Coordinator or carer.

7. Service users have the opportunity to meet their consultant psychiatrist on a weekly basis outside reviews/ward rounds.	?	There are currently five Consultant Psychiatrists working on the ward at the current time all working to slightly different practices. It was stated that practice depended upon the Consultant Psychiatrist involved.
3.0 Facilities available to the service user		
1. A range of social, recreational and occupational therapies and activities is available for in-patients.	✓	Whilst there is no occupational therapy input to the ward, Hollingworth can provide the following: 1. an activities co-ordinator has been seconded (out of the nursing budget) and two nurses (one from each ward) are allocated to activities each shift. This is a temporary arrangement; 2. most of the nursing staff have been trained as gym instructors so they can accompany users to the in-house gym; 3. there are daily sessions on Moorside Ward (upstairs) which users can take part in; 4. there are social activities e.g. film nights; 5. there is a relaxation room upstairs. There is an impressive selection of age and treatment appropriate activities available.
2. There is access to relevant faith-specific support, preferably through someone with an understanding of mental issues.	?	1. There is a multi-faith room upstairs. This not well used. It is called "The Room" as a compromise. Staff were told they could not call it the Faith Room. 2. Representatives of Christian denominations come to the ward. 3. Ward have made contact with representatives of the Islamic faith but they report that: • these do not want to come to the hospital; • users do not want them to come to hospital. Staff believe that this is an issue of stigma. It is unclear what spiritual support other groups receive. Hollingworth Ward does have a multi-faith calendar in order to mark multifaith festivals and holidays.
3. Service users have access to regular outreach visits to community centres promoting	✓	Length of stay on the ward is short but staff report that where appropriate they will take people to outside facilities.

recovery and social inclusion.		
4. Service users are able to leave the ward to attend activities elsewhere in the building and, with appropriate supports and escorts, to access usable outdoor space everyday.	✓	1. Service users can make use of the activities upstairs. 2. The ward does have access to outdoor space.
5. Service users have access to the following within or near to the ward: a. gym; b. library facilities; c. music room; d. computer room; e. prayer/worship room; f. bank facilities; g. canteen; h. basic shop.	✓	1. Gym: there is a gym in the hospital. Some nursing staff have trained as gym instructors. There is also exercise equipment on the ward. 2. Library facilities: there are books and newspaper etc. available. 3. Music room: There is no specific music room, however music resources are available. 4. Computer room: internet access is due to be put into place in July 2011. Some service users bring in their own computers, service users can use the office computer under supervision. 5. Prayer/worship room: Yes 6. Bank facilities: ? 7. Canteen: this is not available at the current time, however a MIND café is due to open shortly and drinks are currently available on the Ward. 8. Basic shop: a social enterprise is being put into the entrance of the building. Work is underway.
6. All service users have access to a range of culturally appropriate resources for entertainment including: a. board games; b. cards; c. TV, VCR/DVD with access to videos and DVDs; d. computer and internet		This is currently achieved as part of the STAR wards action plan. A comprehensive range of board games, DVD's etc. are provided. For computer access (see above).

access.		
7. There is a facility so that service users can access drinks 24 hours a day.	✓	During the day. Drinks can be made available on request at night.
8. Laundry facilities are available to all patients.	✓	Yes.
9. Service users can make and receive telephone calls in private.	✓	Yes. Ward phone and payphone. Service users can also use their mobile telephones.
4.0 Service User Issues		
1. Safe and appropriate admission procedures are in place.	✓	Staff interview and admission processes are safe and covered by protocol. A comprehensive information leaflet is available for both service users and carers at the point of admission.
2. The service user is shown around the ward and provided with all appropriate information.	✓	Information is made available on admission. Staff will go through the information with the service user. Community ward meetings occur twice daily, these meetings support induction.
3. The service user is provided with a ward handbook on admission.	✓	A very helpful and informative leaflet is available.
4. Service user and carer information is available in an appropriate range of formats and languages.	**X**	There is a service user welcome pack. Unclear about languages and formats for people whose first language is not English.

5. Suitable interpreter services are available within appropriate timescales.	?	Interpreters are available but need to be booked in advance.
6. Wards/Units are easily accessible for users, families/carers, visitors and staff, e.g. good public transport system.	✓	Appropriate public transport links and parking is available.
7. The ward provides access to an independent advocacy service.	✓	Yes. See above.
8. There is satisfactory feedback from service user surveys.	✓	Ward report that this is so. But there is a poor return rate. Service users we spoke to were positive. There was a Mental Health Act Commission report on the notice board which was favourable.
5.1 Ward Environment: Dignity		
1. The environment ensures that service user's dignity and privacy is maintained.	✓	1. All service users have their own room. 2. Women-only area accessible by key pad has been established. 3. There is a chaperoning policy. 4. There are appropriate areas for interviews etc. 5. There are separate/ private visitor rooms.
2. Steps are taken to prevent loneliness and isolation.	✓	Care plans focus on therapeutic interventions and engagement. The ward is implementing protected time with services users, and there are also community meetings and a comprehensive range of age and treatment-appropriate activities on the ward.
3. washing and dressing areas are private.	✓	See above. There are no *en suite* facilities on this ward.
4. People are not led to feel embarrassed whilst receiving care and treatment due to environmental restrictions.	?	The clinic room is too small to carry out physical investigation. This has to be done in the individual's room or in the clinic room of Moorside. Service users also have to queue up for medications and this causes privacy issues.

5. The wards are truly single sex with separate: a. sleeping areas; b. toilet and washing facilities c. lounge facilities with; appropriate restrictions on access.	?	Sleeping areas: Mostly, there are some rooms outside the female only area Toilet and washing facilities: Yes Lounge facilities (with appropriate restrictions on access): Yes, but there is restricted access and it does not have a television. A television arial point was due to be put in shortly after our visit.
6. Staff carrying out physical examinations are either of the same sex, or there is a same-sex chaperone present; service users are informed that they can request a chaperone to be present during physical examinations.	✓	Yes.
7. The ward has access to a specific room for physical examination and minor medical procedures.	✓	See above.
5.2 Ward Environment: Safety		
1. The acute ward provides an environment that is safe for users, staff and visitors.	?	1. There are now designated areas for women, accessible by key pad. 2. There are observation problems from nursing station, which is little used. 3. One corridor is difficult to observe, there are a number of recesses. 4. End of the corridor feels unsafe; staff reported that they felt this to be the case. 5. Observation windows have been put into doors but some patients cover these up to keep out the light. 6. There are issues about safety regarding medical, psychiatric and environmental emergencies particularly at night. However most of these issues can be addressed with relatively minor inputs to the environment and the provision of Out of Hours emergency multi-agency plans.
5. The ward environment is appropriate for the use of service	✓	The ward is a refurbished day-hospital and is not ideally suited as an acute ward. However the environment meets this standard.

users and is age appropriate e.g. no ligature and slip or trip issues.		
6. Whilst ensuring levels of security, patients are cared for in the least restrictive environment possible.	✓	• There is freedom of movement around the ward. • Service users can go upstairs for a variety of activity sessions e.g. art, gym, film nights, relaxation sessions, and prayer room. • The ward is locked, it unclear how easy it is to leave the ward. • There is only one lounge that is permanently open, this is used for watching TV and films (some film nights), there is a female lounge but this does not currently have a TV aerial point to be fitted. It is normally locked and is on the main corridor. • The male lounge is usually locked and little used. • There is an activity room on the ward which staff and users can use. • There is an area around the nursing station with table football. This is new and unclear how much this is used. • Service users can access fresh air.
7. Visual observation all parts of the ward is unimpaired.	✓	See above. This remains poor for one section of the ward. However the nursing staff compensate for this by extra vigilance and feel that the establishment numbers are appropriate and enable them to ensure safety.
8. Policies exist, and are implemented, to ensure that an acute ward provides an environment that is safe for users, staff and visitors.	✓	There is a regular health and safety audit conducted with an accompanying risk register. This process has been revised since the incident
9. Alarm systems/call buttons are available to staff.	✓	Staff wear a fob alarm. There are displays in most parts of the ward to indicate where the call is from. Staff feel that the ward is now well covered.
10. There is an agreed procedure between the Trust and the local police regarding response to calls for assistance from acute inpatient	**?**	It is uncertain whether there are formally agreed protocols in place with the Police Service.

services.		
11. There is an agreed procedure between the Trust and the local emergency services regarding response to calls for assistance from acute inpatient services.	**?**	It is uncertain whether there are formally agreed protocols in place with the Emergency Services.
12. There are robust systems in place for the management of problems in relation to alcohol and illicit drugs.	**?**	The ward nursing staff acknowledged that some 25% of their patient group had alcohol and illicit drug problems. The Independent Investigation Team was not told about any formally agreed systems and processes for the management of this in relation to substances being brought onto the ward/ drug dealing etc.
13. Consideration has been given to safety of visitors.	✓ **?**	Carers receive a full set of information about the ward. Ward staff work with them to ensure an induction takes place and support is given. It is unclear what safety measures are put into place for other kinds of visitors.
14. In wards were seclusion is used: a. there must be a seclusion policy in place identifying; b. who can authorise seclusion; c. the maximum length of seclusion; d. how, when and by whom it must be reviewed; e. all episode of seclusions must be recorded; f. seclusion practices and registers must be regularly monitored and audited; g. staff must receive appropriate training.	-	There is no seclusion room on the site.

15. In wards were seclusion is used there must be a designated room fit for purpose. The seclusion room: a. allows clear observation; b. is well insulated and ventilated; c. has access to toilet/washing facilities; d. is able to withstand attack/damage.	-	There is no seclusion room on the site.
5.3 Physical environment		
1. Living conditions in acute inpatient units are pleasant, comfortable and acceptable to the user.	✓	• Service user all have their own room. • The ward is a refurbished day-hospital so less than ideal but staff have made some improvements. • Ward staff have made every effort to ensure the ward is clean and pleasant.
2. The ward/unit environment meets the needs of people with special needs e.g. disability access.	✓	• The ward is on one level and there is a lift to the activities on upper ward, Moorside. • There is a disabled toilet. • Appropriate washing/bathing facilities are available. • Activities and resources are accessible on the ward.
3. Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.	✓	• The ward is in a fairly secluded position and not subject to much external noise. • Most bedrooms are not on the main thoroughfare although several are around the nursing station. • There are a number of rooms which can be used for confidential conversations.
4. There is a designated, appropriate space for service users to receive visits from children.	✓	• Children are not allowed onto the ward. There is a room off the ward where children can be seen. This is shared with the upstairs ward. There are issues relating to supervision/escorting and confidentiality. • Staff report that there are no problems relating to demands for the childrens' room.

5. A separate and appropriate area can be made available to receive patients with police escorts (this may be a designated 136 suite off the ward if possible).	✓	There is a separate 136 suit linked to the crisis and home treatment team offices.
6. The ward environment is not subject to undue noise.	✓	See above.
7. The ward environment is maintained at an acceptable temperature.	**?**	Ward was very warm when the Independent Investigation team visited. Staff reported that temperature control is less than perfect.
8. The ward has direct outside access to fresh air, which is safe and has seating available for relaxation and an area where patients and visitors can converse in private.	✓	There is a pleasant outside area that allows access to fresh air for the service users on Hollingworth Ward.
6.0 Families and Carers		
1. With the knowledge and permission of the service user families and/or carers are appropriately involved in: a. assessment of need; b. assessment of risk; c. care planning.	✓	Staff report that families and carers are involved in assessment. This is supported by the STAR wards programme and extant policy and procedure.
2. Where the carer is looking after someone with 'severe and enduring mental illness': a. a carer's assessment has been conducted; b. there is a written care plan for the carer.	✓	Carers are all offered a carer assessment and care plans are developed with them accordingly.
3. Families and carers are provided	✓	Families and carers are provided with general information about the ward, visiting

with: a. appropriate information; b. in an appropriate format; c. in an appropriate language at the time of admission.		arrangements etc. It is unclear about which languages and formats are also available, however staff will discuss information with visitors/carers face to face as required. There is a friends' and family carers' support group run from the ward that people can attend.
7.0 Staffing and Staff Support		
1. All staff have access to the Trust intranet, knowledge-based systems- such as NHS Evidence, NICE Guidelines, Medline and online journals.	✓	Staff reported that they have access on line information, journals etc. Ward nursing staff explained that this is used a great deal when accessing evidence-based interventions/staying up to date.
2. Staff are aware of current evidenced-based good practice.	✓	There is an on-going teaching programme organised by the modern matron. We did not have the opportunity to see the content, frequency etc of this. Policies and procedures are all up to date and developed using current national best practice.
3. All staff are released from work to attend regular management and clinical supervision.	?	A supervision tree has recently been introduced. Supervision should be once a month but it is too early for the ward staff to say whether this is happening. Handovers are used for informal ongoing supervision.
4. All staff are released from work to attend regular training.	✓ ?	Regular training is conducted for statutory and basic skills. However it is unclear to what extent professionally appropriate CPD is available to nursing staff.
5. The ward is adequately staffed to ensure that operational policy of the ward and professional guidelines can be met e.g. the safe administration of medicines.	✓	Staffing is 4:4:3 Staff reported that (with the activities staff) they have sufficient staff but they feel that they need occupational therapy input.

6. There are sufficient numbers of staff who are knowledgeable and well trained/appropriately qualified.	✓	There is at least one qualified staff member per shift. Staff all receive statutory training. However the lack of access to a truly multidisciplinary team compromises the skills available to service users.
7. The ward has an agreed minimum staffing level across all shifts which is met.	✓	This is achieved.
8. The agreed minimum nursing staffing level includes more than one qualified mental health nurse per shift.	✓	This is achieved.
9. There are systems in place that ensure that all factors that affect staffing numbers and skill mix are taken into consideration, and staffing levels are reviewed on a daily basis. These factors are: a. levels observation; b. sickness and absence; c. training; d. supervision; e. escorts; f. therapeutic engagement; g. acuity levels; h. staff capabilities; i. student training; j. conformance with local Human Resource guidelines.	✓	This is achieved.
10. The ward has timely access to the	**X**	

following services: a. Psychology; b. Occupational Therapy; c. Social Work; d. Administration; e. Pharmacy.	✓	Psychology services are available only if a patient is referred. No Occupational Therapy is supplied. Social Work is accessed on a patient-by-patient basis. Administration is supplied. Pharmacy - yes (see above).
11. The ward has its own dedicated Consultant Psychiatrist who can provide expert input into key matters of inpatient service delivery, staff support and decision making, and overall care service coordination.	**X**	This was not available at the time of the review but it is planned that this will be the case from February 2011.
12. At all times, a doctor is available to quickly attend an alert by staff members when interventions for the management of disturbed/violent behaviour are required, according to documented guidelines or within 30 minutes.	**?**	Currently Yes (an SHO). But the SHO also covers Accident and Emergency which is a ten minute drive away (there is the possibility therefore that this person will be not be available on occasion). There is a plan to move the Accident and Emergency Department (This is out of the control of the Trust) it is as yet unclear what arrangements will be in place when this happens.
13. All staff are able to contact a senior colleague as necessary, 24 hours a day.	✓	This is achieved.
14. All staff are able to take allocated breaks.	✓	This is achieved.
15. Best practice human resources processes are in place.	✓	This is achieved.
16. Staff morale is good as evidenced by staff surveys.	✓	It was reported that staff moral was good. Staff appeared to have high morale when interviewed and visited. However no staff survey was seen by the Independent

		Investigation Team.
8.0 Health and Safety		
1. The site is fully fit for purpose e.g. ground well lit, sound Out of Hour's security systems, enough parking.	✓	There are on-site security guards 24 hours a day, seven days a week. There are issues about security/safety at night should an emergency arise. A new low secure unit is being built but it is not clear whether plans for cross unit protocols have been developed incorporating this new unit. However additional services on the site will serve to improve general site safety.
2. There is management plan to address any shortfalls in the safety of the clinical environment.	✓	There is a regular health and safety audit conducted with an accompanying risk register. This process has been revised since the incident.
3. Regular Health and Safety assessments are conducted.	✓	There is a regular health and safety audit conducted with an accompanying risk register. This process has been revised since the incident.
4. Staff are released for regular health and safety training and all other statutory and mandatory training.	✓	Statutory training is compulsory for all staff. Some mandatory training is now e-learning.
5. There are the required numbers of first aiders on the ward/immediately available at all times.	✓	All staff are trained in basic life support/CPR.
6. There are adequate numbers of appropriately trained staff on the ward/immediately available at all times.	✓	See above.
7. There is a smoke-free policy for staff and patients, which follows HDA guidance and best practice.	✓	The ward is non-smoking area. Smokers have access to the garden.

Appendix Three
Hollingworth Ward August 2007